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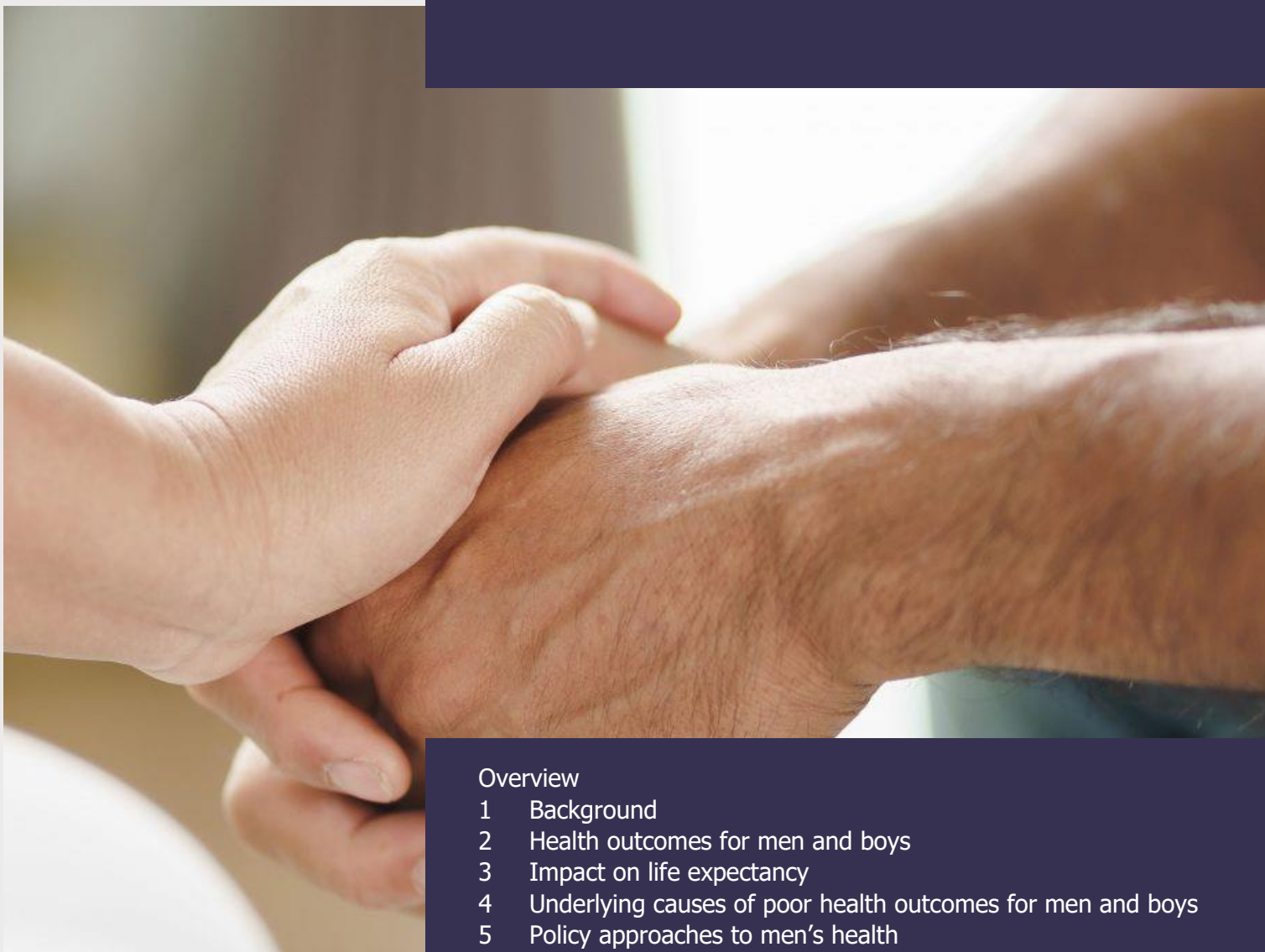
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POSTbrief 56

By David A. Ramsay,
Sarah Bunn

12 December 2023

Men's health



Overview

- 1 Background
- 2 Health outcomes for men and boys
- 3 Impact on life expectancy
- 4 Underlying causes of poor health outcomes for men and boys
- 5 Policy approaches to men's health

References

Contributors

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Contents

Overview	4
1 Background	5
2 Health outcomes for men and boys	7
2.1 Physical health	7
2.2 Men's mental health and wellbeing	13
3 Impact on life expectancy	17
3.1 Life expectancy	17
3.2 Healthy life expectancy	19
4 Underlying causes of poor health outcomes for men and boys	20
4.1 Health inequality and social determinants	21
4.2 Health access, engagement and literacy	25
4.3 Psychological factors	26
5 Policy approaches to men's health	28
5.1 National policy	28
5.2 Community interventions	29
5.3 International policy	31
5.4 Stakeholder and expert perspectives on policy options	33
References	36
Contributors	47

Overview

In the UK, several physical and mental health conditions disproportionately impact men. Men are more likely to experience poor health outcomes for a variety of conditions such as some cancers, heart disease and type 2 diabetes, and are more likely to die by suicide, when compared with women.

On average in the UK, women live almost 4 years longer than men. Although this gap has narrowed historically, it recently widened because of the COVID-19 pandemic. As a result of health and wider inequalities between different groups of men, there are also significant disparities in male life expectancy between some groups of men.

The underlying causes of poor men's health outcomes broadly relate to many interconnected factors such as: socio-economic factors (including income, education, housing and employment), protected characteristics (including disability, ethnicity, sexuality and gender reassignment), behavioural factors (including smoking tobacco, consuming alcohol and physical activity), health-seeking behaviours, health access and psychological factors. There are several risk factors that are more common among men than women in the UK.

Public health policies in England are predominantly condition and outcome focused, rather than focused on sex and gender. However, there are some specific health interventions targeted at men at a national, regional and community level. Evidence suggests that some community-based interventions are effective at engaging with certain groups of men and improving individual health and wellbeing.

Internationally, several countries have introduced national men's health strategies. Stakeholders are calling for similar strategies to be developed in the UK.

Such a strategy might focus on priority areas linked to the greatest disparities for men including certain cancers, suicide, barriers to accessing health services and community-based interventions. It might also include measures to provide a greater focus on this issue, such as through the creation of a body to act as a national research centre for men's health or the creation of a Minister for Men's Health.

In November 2023 the UK Government announced that a Men's Health Ambassador would be appointed along with the establishment of a men's health task and finish group, focusing on increasing awareness of certain conditions and health needs faced by men and improving men's engagement with health services.

1 Background

In the UK, there is growing evidence of inequity in men's health outcomes for many physical and some mental health conditions.¹

Non-communicable diseases such as heart disease, certain cancers, type 2 diabetes, and obesity are just some examples in which disparities arise in incidence* and mortality† rates between men and women.² Other areas of concern include infectious diseases such as COVID-19 and sexually transmitted infections.^{3,4} Data on mental health outcomes also show that men are three times as likely to die from suicide than women.⁵

There is a 4-year life expectancy gap between men (79 years) and women (83 years) in the UK.⁶ For the first time since the 1980s, between 2018 and 2020 there was a decline in male life expectancy.⁶

While this is largely attributed to the COVID-19 pandemic, there has been a significant decline in life expectancy from 2010 to 2019 in many communities in England for both men and women.⁷ The reasons for this decline are complex and are discussed in this briefing's section on life expectancies.

There is also a direct relationship between health and socio-economic status. Men in the most deprived areas in England live nearly 10 years fewer than those in the least deprived.⁸ The gap in healthy life expectancy for these groups is nearly 20 years.⁸

The underlying causes of these men's health issues are numerous, complex and often systemic. They include men's engagement with healthcare, such as attending primary care, some specialist mental healthcare services, and screening uptake; which can be related to men's health literacy.^{‡ 9–12}

Evidence suggests that there are certain health inequalities between distinct groups of men, as well as other populations, including transgender and non-binary communities.¹³

Interconnected factors influencing these inequalities include but are not limited to socioeconomic issues (income, education, housing and employment), other characteristics (disability, ethnicity, sexuality and gender identity), behaviours (smoking tobacco, consuming alcohol and physical activity) and healthcare access.^{14–17} Many of these potential risk factors can

* The incidence rate of a disease is the number of new diagnosed cases of a disease divided by the number of persons at risk of getting the disease over a certain period.

† The mortality rate is the number of deaths caused by a disease in a given population over a certain period of time.

‡ Health literacy is the capacities of people to access, understand, appraise and use information for health.

impact men from a young age and have implications on their health later in life.*

Sex and gender specific health policy in the UK is a current topic of discussion. In summer 2022, the UK Government published the Women's Health Strategy for England, which outlines life course approaches to be employed for improving women and girl's health outcomes.¹⁸

In response to this policy announcement, the Men's Health Forum (a charity with the aim of improving the health of men and boys in the UK) has been leading a campaign for a national strategy on men's health with support from several UK charities and the All-Party Parliamentary Group (APPG) on issues affecting men and boys. The APPG subsequently published a report on "The Case for a Men's Health Strategy" in Feb 2022.¹⁹

In July 2023, the House of Commons Health and Social Care Committee launched an inquiry on men's physical and mental health outcomes.²⁰ Outside the UK, there have been several national men's health strategies including in Ireland (first published 2008) and Australia (published in 2010 and updated in 2019).^{21,22}

Throughout this briefing, the public health data and evidence referred to often use the terms sex and gender interchangeably. Many studies and reports do not differentiate between the terms or do not disclose which they are describing. Therefore, this briefing uses the term men and boys to describe the populations that are the subject of this briefing and may use the term sex and gender to reflect the language used in research studies and policy documents that have been consulted in the preparation of this briefing.[†]

* In this briefing, the term: "men's health" is considered across the whole life course and therefore includes those aged 18 years and under.

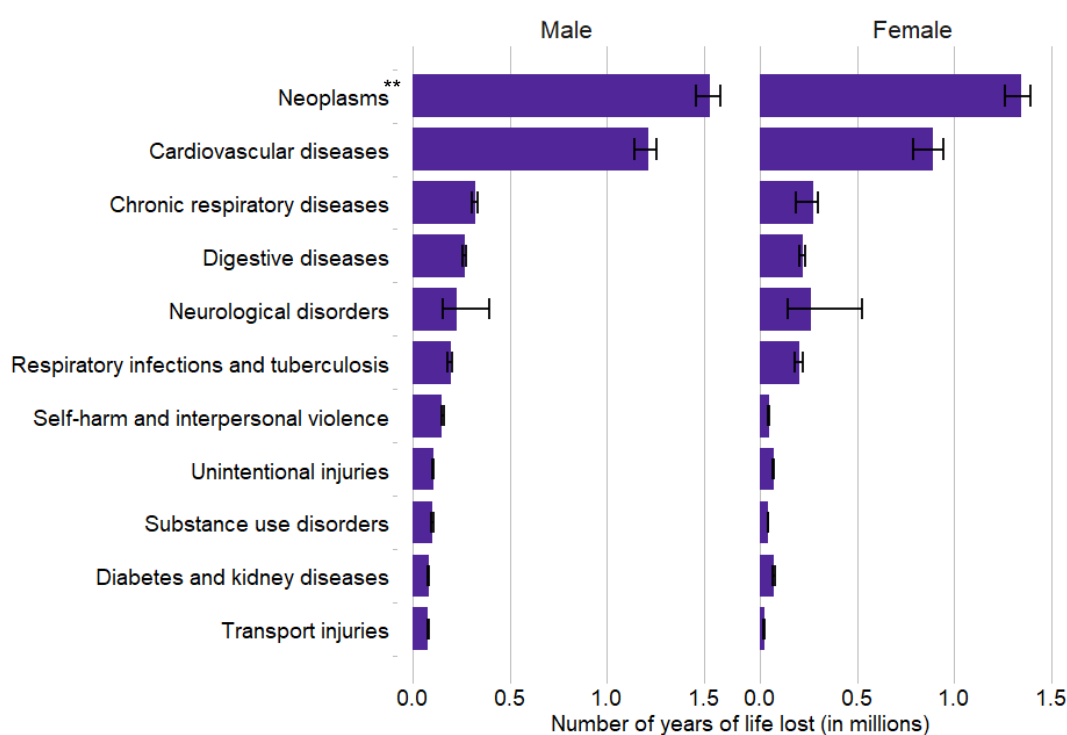
† Sex generally refers to biological and physiological characteristics, determined by sex chromosomes, reproductive function, hormones and their interactions. Gender is commonly understood as a social or cultural identity expressed in terms of femininity or masculinity.

2 Health outcomes for men and boys

2.1 Physical health

The largest proportion of premature deaths (in those aged under 75 years old) in the UK result from cancers, cardiovascular disease (CVD) and respiratory diseases.² Data show that in England, men are more likely to die from these illnesses than women. Figure 1 indicates the causes of premature deaths and how they differ between the sexes.^{2,23} The error bars and their relative size in Figure 1 represent the degree of certainty in the number of years of life lost.

Figure 1 Selected causes of premature mortality* in England 2019



Source: Global Burden of Disease Study, Office for Health Improvement & Disparities.^{2,23}

**Neoplasms are abnormal growths of tissue that can be either cancerous or noncancerous.

* Mortality represents the number of deaths in a group of people over a certain amount of time. Premature mortality refers to deaths of people aged under 75 years old.

Non-communicable diseases

Non-communicable diseases are conditions that do not spread through infection or contact with other people but result from a combination of genetic, physiological, environmental and behavioural factors.²⁴ Non-communicable diseases can often be chronic conditions because of their long duration.

Diseases of the heart and blood vessels (cardiovascular disease, CVD)

Around a quarter of all deaths in the UK are caused by CVD, affecting one in eight men and one in fourteen women.²⁵ Men are more likely to live with and die from cardiovascular disease when compared with women.^{25,26} They are also more likely to experience the risk factors that make developing CVD more likely:²⁶

- individuals are more likely to have CVD if they have one or more of the following risk factors: high blood pressure, smoking, being overweight, type 2 diabetes and high cholesterol.²⁶ Data for England (2012–2017) reported that men are more likely to have risk factors for CVD than women²⁶
- a longitudinal study* in England following over 20,000 people for around 26 years shows that on average, men at age 75 have a 69.1% lifetime risk of CVD in comparison to 57.7% in women, as well as men with CVD having a ~30% higher risk of cardiovascular mortality than women²⁷
- the number of men living with coronary heart disease is almost double that of women (approximately 1.5m vs 0.83m)²⁵
- premature deaths from heart disease (under the age of 75) disproportionately affect men (76% of deaths)^{28,29}

The key CVD risk factors of being overweight and obese and having type 2 diabetes are more common in men than women.^{30,31} In the UK, 69.1% of men and 58.4% of women are overweight or obese.³⁰ Men are also 26% more likely to develop type 2 diabetes and as of 2016 in the UK, 9.6% of men and 7.6% of women were living with some form of diabetes (type 1 and type 2).^{31,32} Diabetes is a significant risk factor for CVD because it results in damage to the inner lining of blood vessels. Adults with diabetes are 2-3 times more likely to develop heart disease, and almost twice as likely to die from it.²⁵

In the UK, certain ethnic groups have been identified as having a higher risk of heart and blood vessel-related diseases.³³ Black African and Black Caribbean groups have a higher risk of high blood pressure and stroke (amongst men in these groups the risk is three to four times higher than the general UK population).^{34,35} Adults belonging to the South Asian ethnic group

* A longitudinal study is a study that measures factors in a group over a period of time, revisiting the same participants at different points. This, and other study methods are described in the [POST Research Glossary](#)

are up to six times more likely to have type 2 diabetes, than the general UK population.³⁵

Prostate Cancer

The prostate is a gland that sits below the bladder and is part of the male reproductive system responsible for producing semen.

Prostate cancer is the most common cancer in men in the UK. It accounted for 27% of cancer cases in men between 2016 and 2018 and 14% of deaths caused by cancer in men between 2017 and 2019 (7% of total cancer deaths).^{36,37}

Reported prostate cancer incidence rates have increased by 8% over the last decade and are projected to rise by 15% by 2040.³⁷ These trends at least partly reflect increasing diagnosis of prostate cancers that may not have caused patients any ill effects in their lifetime.³⁸

The overall rate of prostate cancer deaths measured between 2017 and 2019, have shown that figures have fallen by 10% over the last decade. It is predicted that in England almost 8 in 10 men diagnosed with prostate cancer will survive their disease for ten or more years.^{36,39} These mortality improvements are likely to result from early diagnosis and better treatments.

The prostate specific antigen (PSA) test is typically the first step in prostate cancer diagnosis. It can give false positive results (around three quarters of patients with elevated PSA levels do not have prostate cancer) and also lead to overdiagnosis – where cancers are detected that would not have gone on to cause harm in someone's lifetime.^{40,41} For these reasons, the PSA test is not currently recommended for use in a national screening programme.

Several improvements in other diagnostic pathways include the development of specialised and less invasive MRI scans. These scans may reduce unnecessary biopsies and treatments, and facilitate more targeted biopsies. However, limitations include missing prostate cancers and the patient benefit is unclear.⁴²⁻⁴⁵

The UK Government has announced plans to start a national prostate screening trial (TRANSFORM) using MRI scanning methods in spring 2024.⁴⁶ The £42m screening trial will include hundreds of thousands of men across the country, with the target of 1 in 10 participants being of Black ethnic background.

Men from Black ethnic groups are twice as likely to be diagnosed with and die from prostate cancer in England, than their White counterparts.^{47,48} Prostate cancer can also affect trans women and non-binary people who were registered male at birth.* The risk levels for these groups are not well understood. However they may face certain barriers to care around access, engagement and literacy.^{50,51}

* A trans woman is a person registered male at birth who identifies as a woman. Non-binary is a term used to describe someone who identifies in some way outside of the man-woman gender binary. [POSTbrief 53](#).⁴⁹

Other sex-specific cancers such as testicular and penile cancer have much lower incidence and mortality rates for men than prostate cancer.^{52,53} In the UK, survival for testicular cancer is particularly high with around 65 deaths and 2,400 cases every year.⁵² High survival outcomes for testicular cancer rely on early diagnosis.

Other cancers

In the UK, men are at greater risk of being diagnosed with and dying from cancers seen in both sexes (non-sex specific cancers).⁵⁴ For some cancers, men tend to be diagnosed at later stages than women, contributing to their lower survival:^{36,55,56}

- in the UK, lung cancer accounts for 21% of all cancer deaths in men. In 2017-19, 2491 more men died from lung cancer than women.^{36,56,57} In 2016-18, incidence rates were approximately 10% higher in men than women^{36,55}
- in the UK, bowel cancer accounts for 10% of all cancer deaths in men. In 2017-19, 1579 more men died from bowel cancer than women (9,193 men and 7,614 women).^{36,56} In 2016-18, incidence rates were ~26% higher in men than in women^{36,55}
- while skin cancer incidence rates for men and women are largely similar, men are more likely to die.³⁶ Over the last 10 years skin cancer diagnoses in men have increased by almost 50%, compared to a 30% increase in women.⁵⁸

Smoking tobacco, consuming alcohol and being overweight or obese are the biggest preventable causes of cancer. These risk factors are more common in men.^{30,59} In the UK 14.6% of men and 11.2% of women reported currently smoking cigarettes.⁵⁹

While these and other risk factors might play a substantial part in sex differences in incidence rates, there are also several behavioural factors that play a role in the differences in cancer deaths between men and women.⁶⁰ On average men show poorer recognition of cancer symptoms and are less likely to present to health services with their symptoms than women.⁶¹⁻⁶⁴ This may contribute to later stage diagnoses and poorer outcomes for men.

There are several less common cancers that men are more likely to develop and die from than women. Men are more than twice as likely to develop and die from bladder, oesophagus, and head and neck cancers.^{36,55,56} Similarly, liver and stomach cancers are almost twice as common among men than women.^{36,55,56}

Over the last decade, mortality rates for head and neck cancer in men have increased by around 15% in the UK.⁶⁵ Primary risk factors for the disease are smoking and alcohol consumption, however a growing area of concern is the rise in human papillomavirus (HPV)-linked oropharyngeal cancer* cases among men in Europe and North America.^{66,67} Over 50% of oropharyngeal

*Oropharyngeal cancer is a type of head and neck cancer that affect areas of the throat (pharynx).

cancer cases in the UK between 2002 and 2011 were associated with HPV infection.^{68,69} Incidence of oropharyngeal cancers has now overtaken that of cervical cancer in the UK.⁷⁰ Most cervical cancers in women* are caused by HPV infections. Falling cervical cancer incidence rates since the 1990s have been attributed to the impact of the national cervical cancer screening programme and, latterly, the HPV vaccination programme in England, introduced for girls aged 12 to 13 in 2008 and boys of the same age in 2019.^{70,71}

The Joint Committee on Vaccination and Immunisation (JCVI) advised the Government in 2018 to widen the programme to boys, based on the availability of evidence about the role of HPV in head and neck cancers.⁷² There is no screening programme for head and neck cancer.

Infectious diseases

Infectious diseases are diseases caused by pathogenic microorganisms,[†] such as bacteria and viruses, and can be spread from one person to another.⁷³ Infectious diseases are discussed in more detail in [POSTnote 545](#).⁷⁴ There are several infectious diseases that are more common among men than women.

Respiratory diseases

Respiratory diseases affect the airways and lungs.⁷⁵ Sex differences can be observed for several of these diseases. Globally, asthma and chronic obstructive pulmonary disease (COPD) are more common in adult women, while occupational lung diseases, pneumonia and tuberculosis (TB) are more common among adult men.^{76–80} In the UK, 60.6% of TB cases (2,682 of 4,425 total cases) are diagnosed in men.⁸¹ TB in England disproportionately affects the most deprived populations and most people with TB were born outside the UK.⁸¹

COVID-19, caused by the SARS-CoV-2 virus is another respiratory disease that has impacted some groups differently. Sex differences are evident in both cases and death numbers both nationally and globally. Women are more likely to develop COVID-19 but men are more likely to become seriously ill and die from the disease:

- globally, as of September 2022, ~4.09m men and ~2.91m women have died from COVID-19 related causes. Confirmed cases stand at ~171m for men and ~189m for women^{82,83}
- in England, there have been 86,200 deaths in men and 69,800 deaths in women, with around 8.60m reported cases in men and 10.1m cases in women.⁸²

This sex difference in deaths fluctuated throughout the pandemic, with the greatest discrepancies coinciding with the peaks of infection waves. For

* Cervical cancer can also affect trans men and non-binary people who were registered female at birth.

† Pathogenic microorganisms, or pathogens, are organisms that can cause diseases.

example, in the early stages, between March and April 2020, around 30% more men died than women in the UK.³

The disparities in health outcomes experienced by different groups, including between men and women, as a result of the COVID-19 pandemic has highlighted significant health inequalities in the UK.

The reasons for these disparities are not yet fully understood. There are distinct biological and immune system differences between the sexes that might account for these differences. These differences relate to the way in which genetic factors and specialised cells of the immune system differ between the sexes.^{3,84,85} Other contributory factors include lifestyle and behavioural factors such as hand washing, mask wearing, testing and vaccination uptake.¹

There are also several diseases that increase the risk of people developing severe COVID-19 outcomes. Some of the most common comorbidities* recorded in severe COVID-19 UK cases are heart and respiratory related diseases such as chronic cardiac disease (29%), diabetes (19%), and chronic pulmonary disease excluding asthma (19%), all of which have higher incidences in certain groups of men.⁸⁴

In England between March 2020 and June 2022, there was a disproportionate number of excess deaths in men due to the effects of the pandemic.⁸⁶ Incidence rates of many heavy impact diseases are higher amongst young men and it has been suggested that reduced access to screening, outpatient and regular family practice services may have contributed to these excess deaths.⁸⁷

Sexual health

Several sexually transmitted infections (STIs), such as gonorrhoea, syphilis and HIV are overrepresented in certain groups of men. At-risk groups include gay, bisexual, and other men who have sex with men (GBMSM), young men aged 15-24 and certain Black ethnic groups.⁴ An individual's age, sexual orientation, gender reassignment and ethnicity can also have an impact on their health and wellbeing. This is discussed in more detail in a later section.

In England in 2022, cases of gonorrhoea (82,592) and syphilis (8,692) were at their highest number since 1918 and 1948, respectively. GBMSM account for 47.1% of gonorrhoea and 69.1% of syphilis diagnoses (see Figure 2).⁴

Men are more than twice as likely to have HIV than women (70,560 vs 33,879 in England) and GBMSM make up 43.3% of all diagnoses, with 46,706 cases in 2022.⁴ However, the number of new HIV diagnoses for GBMSM has been declining in recent years and decreased from 784 in 2021 to 724 in 2022.^{88,89} In 2022, there has been the highest ever uptake in HIV testing amongst GBMSM.⁸⁹

There has been a steady decline in genital warts for all populations over the last few years, but most significantly in young people. In England, from 2018 to 2022, diagnoses of genital warts in young men aged 15 to 17 declined by

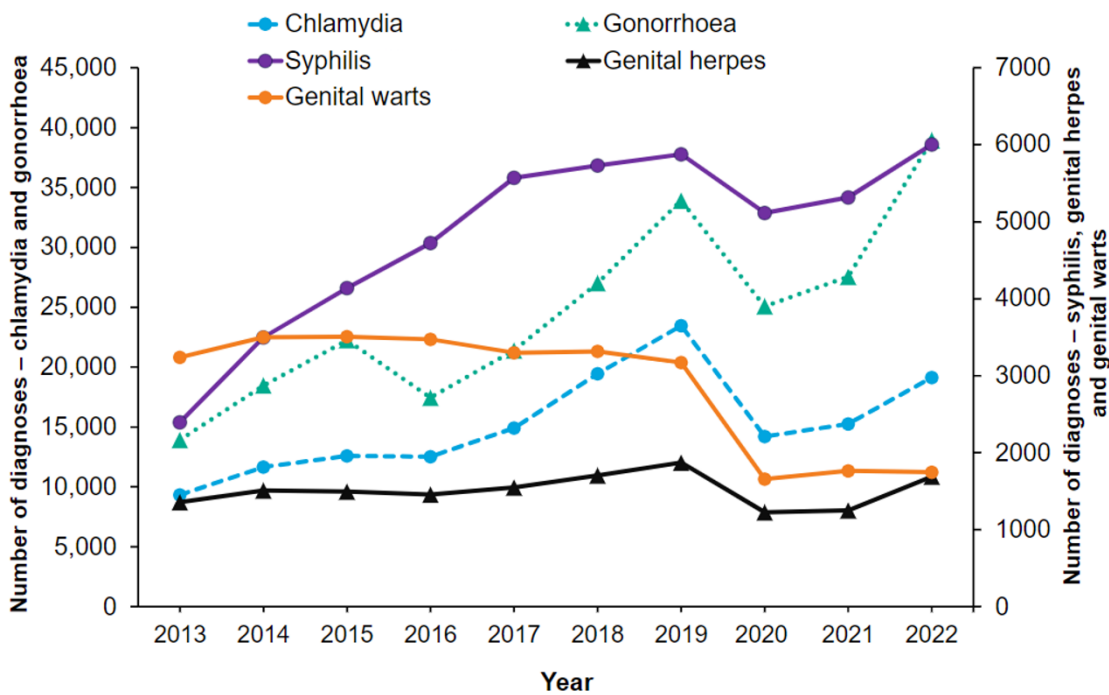
* Comorbidities refers to when an individual has one or more health conditions.

71.5% and in GBMSM of the same age group by 79.3%.⁴ This is likely a result of protection from the HPV vaccination programme that is offered to GBMSM aged under 45 and herd protection conferred across the whole population as a result of the adolescent HPV vaccination programme, now open to both boys and girls aged 12-13.^{4,90}

Other diseases such as hepatitis B and C are less common in the UK, however GBMSM are at greater risk of contracting both infections.^{91,92}

People of Black ethnicity are more likely to be diagnosed with STIs than other ethnic groups.⁴ In England 2022, those of Black Caribbean ethnicity had the highest diagnosis rates of chlamydia, gonorrhoea and syphilis.⁴ Research has shown that there are no unique clinical, attitudinal, or behavioural factors that explain the higher diagnosis numbers. It could be that these rates are being influenced by increased socio-economic disadvantage amongst these communities.^{4,93} The impact of socio-economic factors and ethnicity on men's health is discussed in a later section.

Figure 2 STI diagnoses numbers for gay, bisexual and men who have sex with men (GBMSM) in England



Source: : UKHSA.⁴

2.2 Men's mental health and wellbeing

The prevalence of mental health issues is increasing in the UK.^{94,95} Some mental health charities think that it is unlikely that a complete picture of mental health and general wellbeing is accurately captured in mental health

and other statistics (see Box 1). In addition to academic data, government bodies and other NGOs collate and analyse research to get a better national picture of men's mental health and how it is changing over time. Sources of data include:

- the NHS – collects and publishes data on access to services, treatments and health outcomes for both physical and mental health.⁹⁶ Some NHS data is made available to the research community
- the Office for National Statistics – collects and publishes data on mental health, causes of deaths, drug and alcohol use, inequalities and general wellbeing across the population, broken down by age and sex. This includes data on suicide⁹⁷
- MIND – commissions data from surveys and focus groups to outline men's health in 2009 and 2019⁹⁵
- the Mental Health Foundation – compiled data from various sources to give high level summaries of key issues affecting men⁹⁸
- several men's health charities commission and publish research and data on men's mental health such as Movember and Campaign Against Living Miserably (CALM)
- from 30 November, the Department of Health and Social Care launched a national suicide surveillance system.⁹⁹ This will gather near real-time data on deaths by suspected suicide by gender, age and method.

Overall, these data show that the prevalence of some mental health conditions is lower in men than women, others are more common in men and others are comparable. The main differences in the prevalence of mental health conditions between men and women are described in more detail in Box 1.

Research evidence shows that while women are more likely to be diagnosed with mental health conditions than men, men are much less likely to access psychological therapies than women, and men are more likely to die from suicide.^{94,95,97}

Differences in symptoms and outcomes

The way in which these mental health conditions manifest may differ between men and women, highlighting potential issues with using the same diagnostic tools for both sexes.^{98,100}

Men are also more likely to use coping mechanisms that could be harmful, such as using drugs or alcohol.⁹⁸ Symptoms of depression such as irritability, anger, aggression, drug and alcohol abuse, gambling and other risk-taking behaviours are all more common among men than women.⁹⁸ In England and Wales, men are more than twice as likely to die from drug poisoning than women.¹⁰¹

Accessing care and treatment

Overall trends from a range of data sources suggest that men are less likely to seek care and support than women, although this is improving. MIND reported that men who felt worried were three times more likely to see a therapist in 2019 than in 2009.⁹⁵ However, other data from a YouGov UK survey commissioned by the Mental Health Foundation in 2016, reported that men are less likely than women to seek professional support for mental health or disclose these issues with friends and family.⁹⁵

The NHS collects detailed data on patient access to psychological therapies. The latest data from 2021-22 shows that men of all ages are less likely to access these therapies than women.¹⁰³ Recent YouGov survey data from 2021 reported that men are also significantly more likely to have misconceptions about mental health than women.¹⁰⁴

In addition to the high-level view of men's general care seeking, there is important data at more detailed levels that reveals a more nuanced and complex picture. For example, a recent National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) UK study reported that in 2017, 91% of suicide deaths among middle-aged men came after some form of contact with at least one front-line service or agency.¹⁰⁵ Half of these men had been in contact with mental health services.¹⁰⁵

The factors shaping these attitudes and behaviours are discussed later.

Box 1 Mental health conditions and recent trends

Analysing the epidemiology* of mental health can be challenging. This is because statistics that are collected are unlikely to fully represent the burden of illness. Some research is based on information recorded by the NHS about mental health conditions diagnosed by health professionals, and the treatments that people receive. Other data is drawn from a wide range of research approaches, some of which draw on individual's self-reporting their mental health status, or data on help-seeking and accessing services. Some groups may be under-represented or excluded in research analyses, such as those living in institutional settings (such as prisons) or the homeless.

However, there is high quality data describing some of the most important aspects of men's mental health, including:

- **Suicide** is more common in men; three times as many men die by suicide than women.⁵ The risk of suicide in men peaks between the ages of 45 and 54.¹⁰⁶ Between 2009 and 2019, the number of men having suicidal thoughts doubled to 10%.⁹⁵ POST will publish a separate briefing on preventing suicide in men in early 2024.
- **Anxiety and depressive disorders** are common in men and women, but reported rates are generally higher for women, although this varies with age. Evidence suggests however that rates of mental health conditions amongst men are likely to be underreported.^{94,107}
 - In Great Britain in 2022, 19% of women reported experiencing some form of depression compared to 14% of men.¹⁰⁸
 - The number of men who regularly feel worried or low has increased from 37% in 2009 to 43% in 2019.⁹⁵
 - For those aged 16–25-years, 35% of women and 22% of men experienced moderate to severe depressive symptoms.¹⁰⁸
- **Schizophrenia** is more common in men than in women (globally ~10% higher); a condition that tends to develop at a younger age.¹⁰⁰

Other impacts on wellbeing include issues relating to perceptions of body image and the use of drugs to change the body, such as anabolic steroids, or cosmetic procedures. A House of Commons Health and Social Care Select Committee Inquiry report on the impact of body image on physical and mental health (2022) discussed these effects on men and boys.¹⁰⁹

* Epidemiology refers to the study of how often diseases occur in a population, in which groups and why.

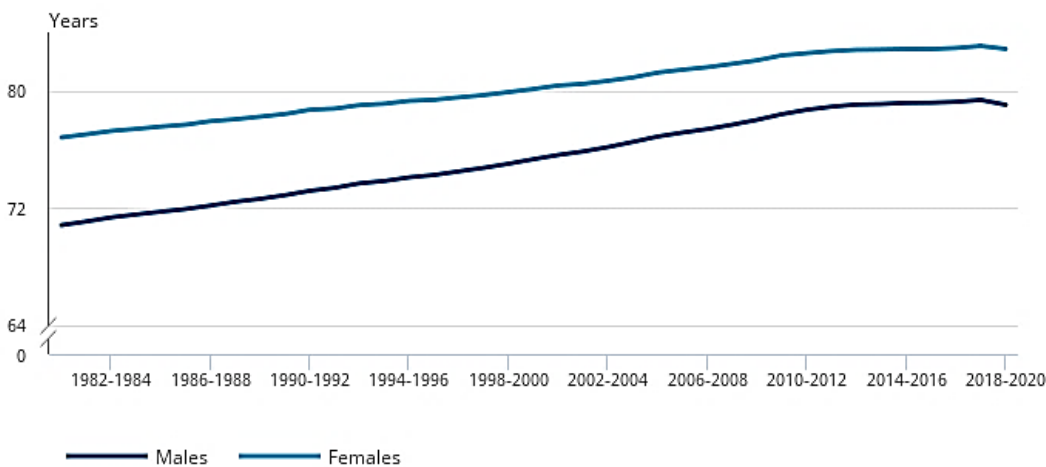
3 Impact on life expectancy

Life expectancy (how long people live on average) and healthy life expectancy (life spent in good health) can be used as metrics for societal progress.

3.1 Life expectancy

Life expectancy has increased steadily since the 19th century for men and women, driven by improvements to nutrition, hygiene, housing and public health.^{110,111} In the UK, life expectancy is 79 years for men and 82.9 for women, as seen in Figure 3.¹¹¹ On average women outlive men by 3.9 years.⁶

Figure 3 Life expectancy at birth, UK, 1982-20



Source: Office for National Statistics (ONS), Office for Health Improvement and Disparities (OHID), The King's Fund.¹¹¹

Between 2011 and 2020 the increase in life expectancy slowed.¹¹¹ As a consequence of the COVID-19 pandemic, figures fell from 2019 to 2020 for both men and women by 1.3 years and 1 year respectively.^{111,112}

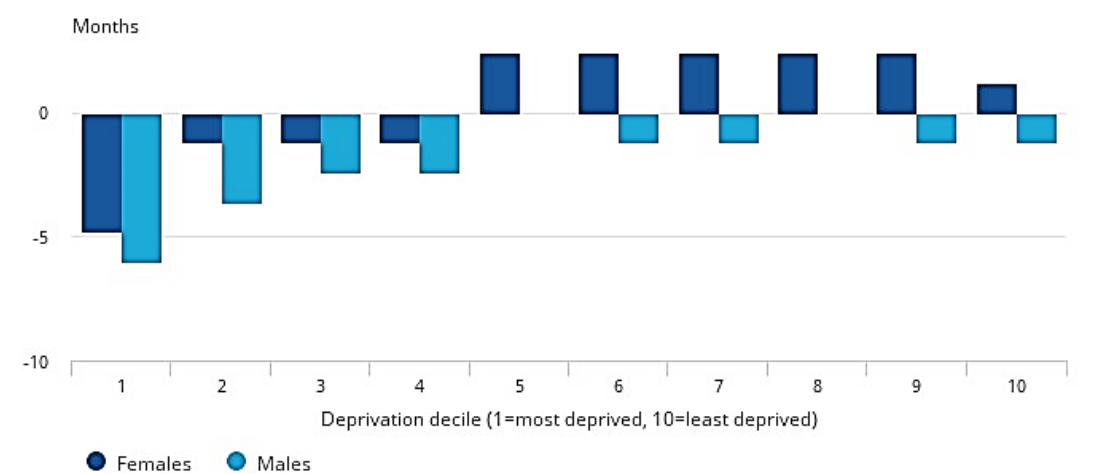
Experts propose several reasons for the pre-pandemic decline in life expectancy improvements, including the increasing difficulty of treating illnesses in an aging population, impacts from years in which influenza caused more illness, slower improvements in heart disease research and the impacts of austerity (including cuts to public spending on services such as health and social care, and social benefits).^{14,113-117}

There is evidence that socio-economic inequalities in life expectancy have widened in England since 2011. The gap in life expectancy between the most and least deprived groups (called deciles*) between 2011-13 and 2018-20 increasing by 0.7 years in men and 1.1 years in women.^{8,111}

Several studies in England, show significant declines in life expectancies in several deprived communities between 2010-2019.^{6,7,14,111,119,120} Figure 4 shows recent changes in life expectancy for England across the least and most deprived populations between two periods - 2015 to 2017 and 2018 to 2020:

- life expectancy decreased significantly for both men and women in the most deprived groups. The largest decreases were in men⁸
- men in the least deprived groups experienced small decreases in life expectancy. Life expectancy for women increased in these groups⁸

Figure 4 Changes in life expectancy by deprivation decile in England, between 2015 to 2017 and 2018 to 2020



Source: Office for National Statistics (ONS).⁸

* Deprivation deciles are calculated by ranking the 32,844 small areas in England from most deprived to least deprived and dividing them into 10 equal groups.¹¹⁸

3.2 Healthy life expectancy

Other measures describe how long people live in good health (healthy life expectancy*), or live free from disabilities (disability-free life expectancy†). In the UK, while the life expectancy gap between men and women stands at 3.9 years, the gap for healthy life expectancy between men and women is smaller at 0.8 years.¹²¹ On average although women live longer than men almost all additional lifetime is spent in ill-health.

There has been no significant change in healthy life expectancy across the UK between 2015-17 and 2018-20 however, disability-free life expectancy has declined significantly for both men and women by 0.8 and 1.2 years respectively (an average of 62 years for men and 60.7 years for women).¹²¹

As with life expectancy, healthy life expectancy and disability free life expectancy vary with socioeconomic status. In England, between 2015-17 and 2018-20 men in the most deprived decile had a healthy life expectancy 18.6 years fewer than those in the least deprived, while for women there was an equivalent gap of 19.3 years.⁸

* Healthy life expectancy is an estimate of how many years a person will live in good health, based on contemporary mortality rates and how they perceive their own general health.^{23,111}

† Disability-free life expectancy is an estimate of how many years a person will live free from persistent illness that limits day-to-day activities, based on self-rated assessment.¹²¹

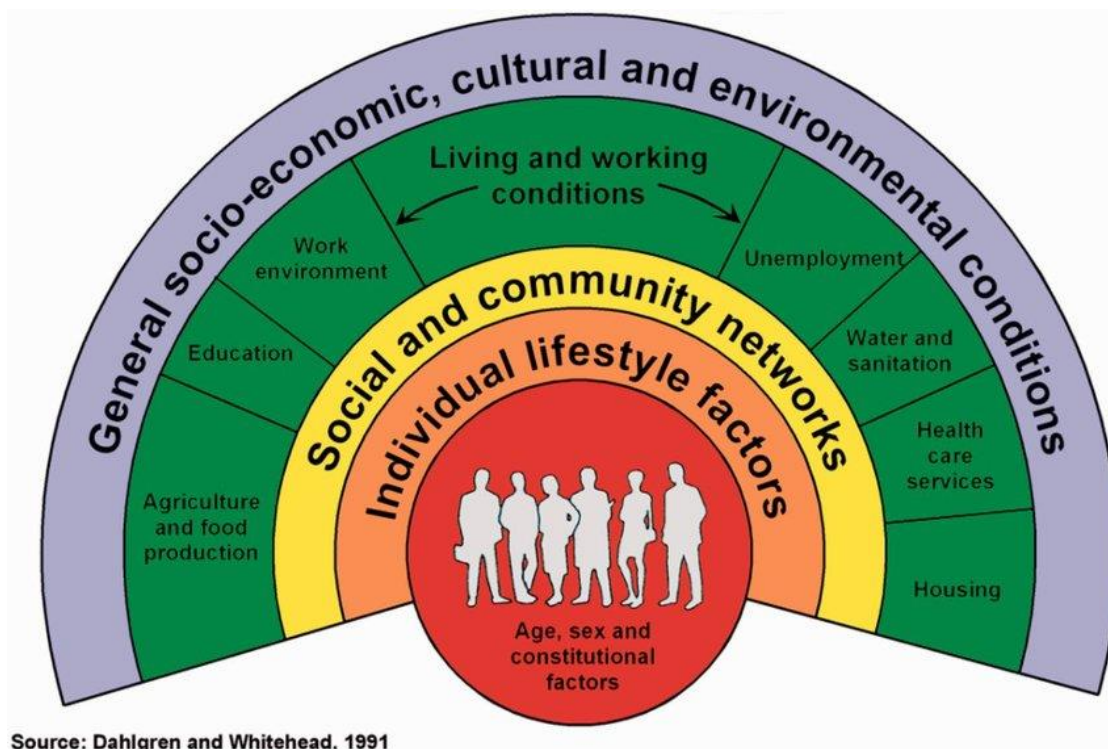
4

Underlying causes of poor health outcomes for men and boys

The reasons for a given individual's poor health can be numerous and complex. In most cases, there are likely to be several contributing factors that each have an interconnected influence on the other. Often behavioural factors are influenced by more systemic environmental and social determinant factors related to health and wider inequalities. Similarly, health engagement, health literacy, behaviours and male gender norms can vary with an individual's culture, community, and socio-economic status.

The broad social and economic circumstances that determine the quality of an individual's health is described in Figure 5. This academic model of health determinants centres on personal characteristics (sex, age, ethnicity), working outwards to lifestyle factors (behaviours such as smoking, alcohol use, physical activity), social and community networks (family and wider social circles), living and working conditions (access to housing, education, welfare services) and then general socio-economic, cultural and environmental conditions (disposable income, taxation, availability of work).¹²²⁻¹²⁴

Figure 5 The interacting factors that determine individual health



Source: Dahlgren and Whitehead, 1991

Source: Eikemo et al. (2016),¹²² Dahlgren and Whitehead (1991).¹²³

4.1

Health inequality and social determinants

Income and employment

Having sufficient household income and being in work are associated with good health outcomes and higher life expectancies.¹²⁵ Living on a low income is associated with stress, lower access to health-improving goods, and can influence certain health-affecting behaviours.¹²⁶ Employment rates for both men and women are significantly higher in the least deprived areas of England (80.1%) in comparison to the most deprived areas (68.6%).¹²⁷

Education

Many studies show that educational attainment and degree of qualification are key social determinants of health.^{16,128–130} Among 26 OECD countries, people with a university degree or equivalent at age 30 live over five years longer than people who attain lower levels of education.^{125,131} UK wide statistics show that boys consistently achieve fewer school-level qualifications and go into adulthood to make up lower numbers of further and higher education students than women.^{132,133}

Geography

Health outcomes in England vary with geographical location and are linked to local area deprivation metrics. Some evidence points towards a north-south divide in health outcomes in several areas.¹¹⁹ For example, the 10.7-year life expectancy gap between men living in Westminster (London) and Blackpool (North West).¹¹⁹ Some stakeholders have highlighted that this is an oversimplification and have suggested that areas of deprivation in urban environments and coastal towns all over the country are of concern for men's health.^{15,134} Healthcare services may be less accessible in rural communities and require people to travel longer distances for care.¹⁵

Housing and homelessness

Poor health outcomes such as cardiovascular and respiratory diseases and mental health conditions have been linked to living in overcrowded and poor-quality housing.^{125,135} People experiencing insecure-housing and homelessness have poorer health outcomes when compared to the general population.^{15,136} In the UK, men account for 85% of people sleeping rough.^{*137}

* The term sleeping rough refers to homeless people actively bedding down in the open air or in buildings not designed for habitation.

Refugees and asylum seekers

Evidence for the health status of asylum seekers and refugees is limited and trends are not consistent across all groups.¹³⁸ Data from a WHO European Region report suggests there are poor outcomes around mental health issues in both male and female asylum seekers.¹³⁸ Evidence of barriers to refugees accessing health services such as communication difficulties, cultural issues and bureaucratic barriers exist.^{138,139} In 2022, over 80% of those applying for asylum in the UK were boys and men (62,486 boys and men compared with 11,920 girls and women).¹⁴⁰

Occupational Health

The environment and conditions in which people work may have an impact on their immediate and long-term health. Workplace hazards and risks include physical injuries, musculoskeletal disorders, and illnesses (such as respiratory conditions and some cancers) resulting from exposure to hazardous substances. Other workplace hazards include psychosocial factors like stress, bullying, harassment and violence.^{100,141} Globally, men of working age are almost three times as likely to die from occupational risk factors than women.¹⁴² Data from a 2023 Health and Safety Executive report showed that in Great Britain 96% of fatal injuries in the workplace were among men.¹⁴³ In 2005, an estimated 8,000 cancer deaths were attributable to occupation in Great Britain (5.3% of total cancer deaths), of which around 6,400 (8.2% of total) were men and around 1,700 (2.3% of total) were women.¹⁴⁴ Exposure rates to carcinogens like asbestos are highest for engineering, maintenance and construction workers, the majority of whom are men.⁷⁶

Age

Despite health disparities discussed previously, men aged over 75 is the fastest growing population group in the UK. By 2050, this group is projected to grow by 81% compared to 70% in women.^{1,145} An ageing population brings many challenges for healthcare and other services, particularly in relation to cardiovascular disease, cancers and neurodegenerative diseases like Alzheimer's disease and dementia. In England and Wales in 2022, heart diseases were the leading cause of death for men (38,730 deaths, 13.3%) followed by dementia (23,332 deaths, 8%). Dementia is a growing area of concern in older men with 2,332 more deaths associated with the illness in 2022 than in 2021.¹⁴⁶

Race and ethnicity

The impact of ethnicity on health outcomes is complex. In England, prior to the COVID-19 pandemic, mortality amongst most ethnic minority groups and foreign-born migrants (adjusted for differences in age) was lower than White ethnic groups.^{15,33} This is often attributed by experts to lower rates of smoking and alcohol consumption and the "healthy migrant effect".^{* 33} This

* The "healthy migrant effect" is where migrants have a lower mortality than the general population of a given host country. Reasons for this increased mortality could include the higher likelihood of healthier individuals to migrate, often with healthier lifestyles such as lower smoking and alcohol consumption.

health effect among migrants has been shown to fall over time and is reduced in UK-born descendants.³³ However, since the COVID-19 pandemic much of this gap in mortality rates between ethnic groups has narrowed. This is primarily because of higher rates of certain pre-existing conditions such as type 2 diabetes or heart conditions, vaccine hesitancy and the overrepresentation of ethnic minorities in frontline services who were at high risk because of their exposure to the virus.^{33,125} As previously discussed, there are also significant disparities in poor health outcomes for men of Black and South Asian ethnic heritage. At-risk groups for heart diseases include Black African, Black Caribbean, and South Asian men.^{34,35} South Asian men are at particular risk of developing type 2 diabetes.³⁵ There is much higher risk of prostate cancer amongst Black men than other ethnic groups.^{47,48} The reasons for ethnicity-related disparities in certain diseases are not well understood but evidence suggests a combination of genetic, environmental, deprivation and behavioural factors.³³

Sexual orientation and gender reassignment

Evidence suggests that people's sexuality and gender identity is linked to several health outcomes. Sexual health, mental health and increased risk of smoking, alcohol, and drug abuse are recurring factors highlighted in research on these communities.¹⁰⁰ Gay, bisexual, and other men who have sex with men (GBMSM) are at increased risk of certain sexually transmitted infections such as HIV, HPV, gonorrhoea and syphilis.⁴ Evidence suggests that among transgender and non-binary populations there are higher prevalence of anxiety, depression, self-harm, and suicidality when compared to the general population (see [POSTbrief 53](#) for further information).^{49,147,148}

Lifestyle and behaviours

Tobacco smoking

In England 2019, smoking was the leading preventable cause of illness and premature death, killing an estimated 75,000 people.¹⁴⁹ Across all deprivation deciles men are more likely to smoke than women. In the most deprived areas, 27.6% of men are smokers compared with 20.3% of women.¹⁵⁰ Behavioural support via stop smoking services are considered one of the best ways to help people quit smoking and men are less likely to use these services than women.¹⁵¹⁻¹⁵³

Weight and dietary risks

Between 2003 and 2017 in England and Scotland, evidence shows that deaths attributed to obesity and excess body fat had increased from 17.9% to 23.1%.¹⁵⁴ Nationally, men are more likely to have excess bodyweight than women.³⁰ Evidence suggests that this disparity in obesity begins in childhood. In 2021/22 in England, for children entering school reception (at age 4-5), 10.6% of boys are obese compared to 10.2% of girls. By year 6 (age 10-11), 26.5% of boys are obese compared to 20.3% of girls.¹⁵⁵ Obesity is somewhat more prevalent in the most deprived areas of the UK when compared to the least deprived areas (66.6% vs. 58.8%).¹⁵⁶ Longitudinal study data in the UK from 2010 has shown that men tend to eat more processed or confectionary foods when compared to women.¹⁵⁷

Drugs and alcohol

The misuse or overconsumption of drugs and alcohol can negatively impact people's health. They are risk factors for an increased risk of developing heart and liver diseases, numerous cancers and some mental health conditions.¹⁰⁰ The overconsumption of drugs and alcohol are associated with poor mental health, with studies showing that they are sometimes used as a coping mechanism to manage emotional distress. In England across all ages (from 16 to 75+), men are more likely to consume over 14 units of alcohol per week than women (14 units is the level considered 'low risk' but for cancer, there is no safe level of drinking).¹⁵⁸ Data from the Office for National Statistics (ONS) reports that men in England and Wales are 2.5 times more likely to die from drug misuse than women (2,206 men and 854 women in 2021).¹⁰¹

Accidents and injury

Globally men account for almost two thirds of unintentional injury related deaths (2m male deaths vs. 1.1m female deaths).^{100,159} Men are at greater risk of both domestic and occupational accidents.¹⁰⁰ Road traffic injuries make up the largest proportion of unintentional injury. In the UK, 75% of road fatalities and 62% of casualties of all severities were in men.¹⁶⁰ Groups at higher risk include boys and young men (under the age of 25), who are three times more likely to be killed in road traffic accidents than girls and young women.¹⁶¹

Family and interpersonal relationship dynamics

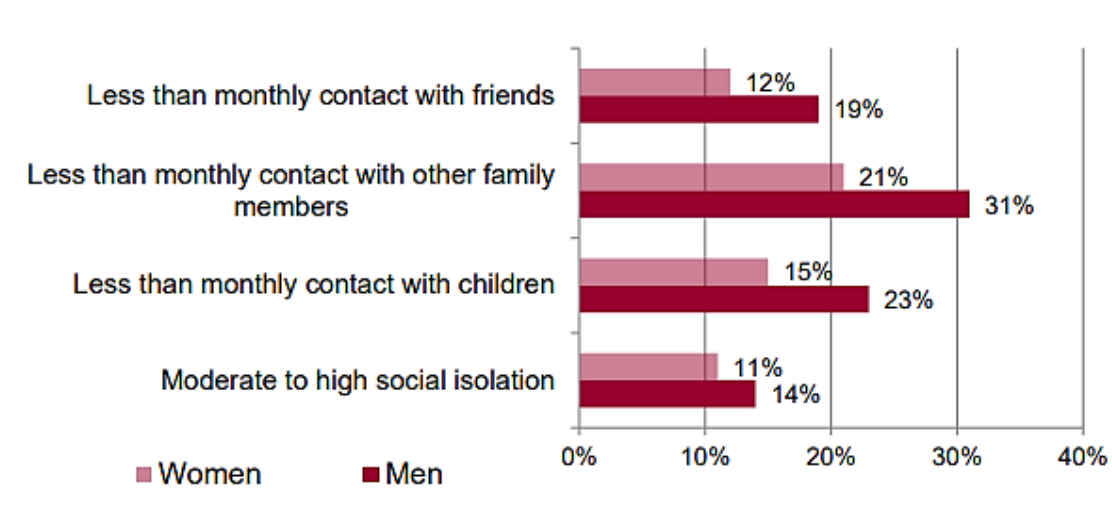
Men's relationship dynamics with their partners and children can impact their mental and physical health. Stakeholders have highlighted a wide range of issues such as relationship breakdown, family proceedings in courts, involuntary childlessness, male infertility and young fatherhood.^{100,162-165} Male infertility is a growing area of concern with a global 2022 study showing that average sperm concentration has decreased by over 50% between 1973 and 2018.¹⁶⁴ The reasons for the global decline in sperm count are not well understood, however potential candidates include increased rates of obesity, poor diet and exposure to environmental pollutants.¹⁶⁶ Globally, around 7% of men are affected by infertility and 50% of heterosexual couple infertility has a male component.¹⁶⁷ In the majority of cases the cause of male infertility cannot be determined, however the most common issues are poor quality semen (semen with low sperm count and/or slow moving or abnormal sperm) and problems affecting the testicles, related to conditions such as undescended testicles or testicular cancer.^{168,169}

Social isolation and loneliness

Men's social relationships impact their mental and physical health.¹⁷⁰ Evidence suggests that these factors are associated with mortality and mental health conditions, including the risk of suicide.¹⁷¹⁻¹⁷⁵ Older men over the age of 50, are more likely to experience social isolation and loneliness than women of a similar age.^{170,171,176} Data from a longitudinal study on aging presented in Figure 6, highlights some of the disparities in self-reported isolation indicators for over 50s in England.^{170,176} The causes of social isolation and loneliness are complex and numerous, but relate to age, education, poverty and geographical location.¹⁷¹ The reasons for the disparities between men and women are not well understood but might

relate to women being more likely to create stronger social networks in their lives as well creating new close relationships, whereas men are more likely to derive their social support from their partner or family.^{171,174,177,178}

Figure 6 Isolation among men and women aged fifty and over: England, 2012/13



Source: Public Health England, UCL IHE, 2015; Beach and Bamford, ILC 2014; analysis of data from the English Longitudinal Study of Ageing (ELSA).^{170,176}

4.2 Health access, engagement and literacy

In general, available data suggests that men access and engage with health services less than women.¹⁷⁹ In England, between 2019 and 2020, men comprised 42.1% of outpatient attendance.¹⁸⁰ Even excluding maternity-related attendances, women make up a larger proportion of outpatient attendances than men at all age ranges except for the very young and the elderly.¹⁸⁰ Take up rates for the NHS Health Check (a general health assessment open to those aged 40-74) amongst men were 46% compared to 54% in women.¹⁸¹

Stakeholders have highlighted that for many younger and middle-aged men, there often appears to be little need to engage with healthcare services until things are too late.

Women engage with services from a younger age to access contraception, when they are invited to attend national screening programmes for cervical cancer (from age 25), to access maternity-care and, later in life, to attend breast cancer screening (starting at age 50).¹⁸²

In comparison, other than immunisations, services offered to men begin at age 60 for bowel cancer screening (offered to both men and women, although the age is lowered to 50 in a phased approach) and then at age 65 for abdominal aortic aneurysm (AAA) screening (offered to men only).^{182,183} Men are also less likely to participate in bowel cancer screening than women (47% uptake in men compared with 56% uptake in women).^{184,185}

The most cited reasons for not attending healthcare services amongst men are the inability to get time off work, inconvenient opening times, long waiting times, potential loss of earnings and not being aware of the services available to them.^{186–188}

Men's health seeking behaviours are also influenced by their perceptions of masculinity and their reluctance to attend services could relate to embarrassment and the stigma associated with these notions.¹⁸⁹ The psychological factors associated with health seeking behaviours is discussed in further detail in the following section. Other possible reasons for lower attendance among men could be related to health literacy issues such as poorer symptom recognition and the misunderstanding of health risks.⁹

Several studies have shown that men have lower levels of health literacy than women.^{9,10,190,191} Stakeholders have highlighted cancer as a particular problem area. There is evidence that shows men have poorer awareness and recognition of cancer symptoms than women.^{188,192,193}

In the case of bowel cancer screening for example, it has been shown that men are less aware of the screening process and have a poorer understanding of how it works than women.^{194,195} These factors may contribute to lower uptake in these programs amongst men, later stage diagnosis and lower survivability.¹⁹⁵ The symptom recognition and health literacy about testicular cancer has also been highlighted by stakeholders as an important area. Early detection of the disease through testicular self-examination is recommended by health professionals, but studies have shown that young men rarely practice monthly self-examination.^{196,197}

Health literacy is associated with socio-demographic and geographic causes of poor health and with engagement in health promoting activities.¹² Modelling has indicated that improving health literacy may reduce health inequalities through supporting reduction in unhealthy behaviours (smoking) and reducing the risk of developing long-term health conditions, with benefits seen mostly in the most deprived groups within the population.¹⁹⁸

4.3 Psychological factors

Many of the underlying causes of poor men's health are influenced by psychological factors. One factor highlighted by several stakeholders is the impact and perception of masculinity.^{15,100,189,199–201}

The relationship between the perceptions of masculinity and men's health is not well understood. Research studies in the area vary in methodology, with either quantitative and qualitative data normally sourced from rating scale style surveys and interviews of both men and women.^{200,201}

There is evidence that suggests traditionally masculine behaviours, socialisation, lifestyle and beliefs have an impact on men's health in one of two ways: their risk-taking behaviours and their underutilisation of health services.^{15,199} Risk-taking behaviours associated with masculinity include substance misuse, poor diet choices, violence and aggression, reckless driving and risky physical activities.^{199,202}

Reduced health seeking behaviours (both in mental and physical health) have been linked to certain masculine ideals around stoicism and strength, however some studies dispute the impact of gender in this area.^{60,62,199,201}

The positive aspects of masculine norms and their influence on male health seeking behaviours are under-researched. There is some evidence that suggests because certain fathers or male caregivers are more likely to have better health than other men, self-care is prioritised because of the need to care and protect others.^{189,203} Stakeholders have suggested that more research is required into positive masculine norms and have highlighted that the narrative around traditional masculinities is deficit-based.¹⁸⁷

In the area of healthcare, it is suggested that taking a more positive strength-based model on masculine norms could help engage certain men by affirming their masculine identities.¹⁸⁷ Community based health interventions targeted at men often draw upon these positive masculine norms and are discussed later.

5 Policy approaches to men's health

Men's health interventions in the UK are undertaken at a national, local and community level. Healthcare services and other interventions are provided by a combination of the NHS, national charities, local authorities and community-led organisations. Each of these levels of healthcare and other sources of support is discussed in the following sections.

The UK Government's current approach to public health policy is predominantly disease and condition focused. This has been highlighted in the recent publication of the Major Conditions Strategy by the Department of Health & Social Care, in August 2023.²⁰⁴

This strategy aims to tackle the main causes of ill-health by determining the best approaches to prevent, diagnose, treat and manage six major groups of conditions: cancers, CVD, chronic respiratory diseases, dementia, mental ill health and musculoskeletal disorders. The strategy reports that it will consider the wider determinants of health and the differential impact of factors such as gender and ethnicity.²⁰⁴ It is too early to evaluate the impact of this strategy on men's health in England.

In 2022, the Women's Health Strategy for England was published by the Government. There is currently no equivalent national strategy in place for men, which has been highlighted by stakeholders as a potential health inequality. Suggestions for a men's national health strategy as well as examples of current international examples is discussed in the following sections.

5.1 National policy

The NHS's abdominal aortic aneurysm (AAA) screening for men aged over 65, the HPV vaccination programme for GBMSM and the recently announced national prostate screening trial (TRANSFORM) are some examples of population level healthcare targeted at men or certain groups of men.^{46,205}

Alongside the announcement of the TRANSFORM prostate cancer trial in November 2023, the UK Government also announced that a Men's Health Ambassador would be appointed along with the establishment of men's health task and finish group, focusing on improving men's engagement with health services.⁴⁶ Most other national policies that are likely to improve men's health are focused on the general population and on specific conditions and outcomes. For example:

- the suicide prevention strategy for England: 2023 to 2028, which names middle-aged men (ages 40-54) as one of its priority groups for targeted support²⁰⁶

- stop smoking policies such as the recently proposed legislation to prohibit anyone born on or after 1 January 2009 from ever being legally sold tobacco products in England²⁰⁷
- community diagnostic centres set up in October 2021 designed to offer health interventions in more convenient community-based locations across England.^{208,209}

Some stakeholders also note the public health impacts for men of alcohol minimum unit pricing policies, like that introduced in 2018 in Scotland. The current minimum price for a unit of alcohol in Scotland is 50 pence.^{210,211}

While policies like these may indirectly have a positive impact on men's health outcomes, stakeholders in men's health are calling for approaches designed for and targeted at men, and specifically for a national men's health strategy.^{1,19} Stakeholders acknowledge the importance of the recently published Women's Health Strategy for England and point to national men's health strategies like those in Ireland and Australia as example models to draw from.^{1,19}

5.2 Community interventions

Outside of national health policies, over the past 20 years there has been a major increase in male-targeted local and community-led health initiatives in the UK.

The growth in this area has predominantly been through grassroots men's health charities and NGOs in the voluntary sector and particularly in the areas of mental health, weight loss and physical activity.²¹² The provision of community services comes from a variety of different organisations.

Some charity organisations are supported fully through public donations and volunteers while others work more closely with the NHS and local authorities. Some interventions are often commissioned through grassroots movements or where a particular need within a community arises, while in other cases they are designed and implemented as part of wider national or regional campaigns.

Outcomes from community interventions can be hard to evaluate, particularly in mental health.²¹³ Many organisations highlight improvements in member's self-reported wellbeing and point to growth in the uptake of services as evidence of good outcomes. Quantitative research and evaluation studies have been conducted in some cases (see Box 2 for Men's Sheds case study). However in general there is more research focused on design principles than participant outcomes.²¹³

The National Institute for Health and Care Excellence (NICE) has guidance on good practice for community health engagement.²¹⁴ It stresses the importance of such programmes integrating projects into communities by allowing for community-led organisation and decision making. There should be an emphasis on providing interventions to meet specific needs of the community and its members, designing approaches on a case-by-case basis.

The importance of giving evaluation and feedback of interventions to the wider community and other partners is also highlighted.²¹⁴

Case studies for community interventions include:

- **UK Men's Sheds Association.** This provides informal community workshop-type spaces (Sheds) where men can take part in practical craft activities and socialise with other men. The Men's Sheds model originated in Australia and has now spread internationally, with the UK association growing from 30 Sheds in 2013 to 600 in 2021.^{215,216} Many studies and evaluations have been published on Men's Sheds effectiveness. An extensive EU-funded evaluation project examined projects in Belgium, France, the Netherlands and the UK called the Step-by-Step Project.²¹⁷ These studies have evidenced multiple benefits to participants in the areas of mental and physical health, social wellbeing and skills and employment development.^{216,218–222} Box 2 details the health benefits of Men's Sheds.
- **Andy's Man Club.** A suicide prevention and men's mental health support charity that provides spaces for men to come together and talk openly about their mental health struggles. The clubs are open to all men over the age of 18 and the focus is placed on providing a community-led environment in which men can feel more comfortable talking about their emotions and wellbeing. The organisation has grown rapidly over the last 3 years and now operates 157 locations across the UK with around 22 staff members, over 1,000 facilitators and around 3,600 men attending every week.²²³
- **Rugby League Care's Offload project.** Rugby League Cares is an independent charity that supports the health and wellbeing of rugby league players. It also delivers mental health programmes to children, young people and adults living in rugby league communities, which include several areas of high deprivation. Offload is an adult mental fitness programme designed by men for men and delivered by current and former rugby league players. It uses sporting activities as a platform to breakdown stigmas associated with mental health, reduce barriers to accessing support, help men learn techniques for managing their mental fitness, increase men's support networks, and increase help-seeking behaviours..²²⁴

Sport-focused physical activity interventions like the Offload project provide male-friendly environments and draw upon traditional masculine ideals like competitiveness and comradery to encourage men to disclose and address their health issues.^{224–226}

A qualitative study in the East of England investigating men's experiences of living with obesity indicates that commercial weight management programmes tend to be ineffective and detrimental for men.²²⁷ Men interviewed in the research suggested that practice-based programmes involving sport or physical activity would be more engaging and effective than traditional approaches that involve group discussions of achievements or shortcomings.²²⁷

Stakeholders have highlighted difficulties with the scaling up of these projects to a national scale.^{228–230} These difficulties have been experienced in

the case of Ireland's national men's health policy, however community-led men's health interventions have also been cited as one of their major success areas.

Box 2 Community intervention case study: Men's Sheds

Men's Sheds are not recognised as formal healthcare services. However, several studies have shown that there are many positive mental and physical health impacts for members.^{216,218–222,231,232}

The combination of practical and social activities undertaken at Men's Sheds have been shown to improve individual's mental health and wellbeing. Examples include decreasing depression, improving confidence and self-esteem, and lessening the impacts of social isolation and loneliness.^{218–221,233}

Studies have also shown that there are many physical health improvements observed in Men's Shed participants such as: improved physical fitness, improved mobility, better resistance to injuries, healthier diets, decreased alcohol and substance abuse and better physical health literacy.^{216,222,234,235}

Studies have also shown that Men's Sheds are effective at targeting male population groups who may have certain barriers to accessing conventional healthcare. Among these are older men, those who are socially excluded, unemployed or affected by negative life experiences.^{216,236–238}

5.3

International policy

World Health Organization

In 2018, the World Health Organization (WHO) Regional Office for Europe published a men's health strategy and report.^{239,240} This report was the first of its kind published by WHO and focused on reducing premature mortality among men, improving health and wellbeing, reducing inequalities and improving gender equality. The report provided evidence of poor health outcomes for men across the region and advocated for more gender-responsive and equity-driven approaches to health policy.¹

Ireland

Ireland's National Men's Health Policy 2008 – 2013 was the first national men's health strategy in the world.²¹ The strategy took a holistic approach, giving roles to both government and non-government bodies, and focusing on preventative solutions and developing community health interventions.^{1,241,242} It also emphasised the importance of encouraging a

positive narrative around men's health and advocating for men to become more active in their own health engagement.

Stakeholders have noted that the strategy might have been too ambitious and broad in scope, particularly in the context of the 2008 financial crisis and subsequent economic recession.²⁴¹ A 2015 strategy review reported positive outcomes relating to health promotion initiatives, community-based programmes and training for health professionals.²⁴² Box 3 outlines further details about Ireland's National Men's Health Policy and its impact.

Australia

The Australian National Men's Health Strategy 2020 – 2030 focuses on developing a health system using a more gender-specific approach – consciously considering the needs and preferences of men in the design, delivery, promotion and continuous improvement of the information, programs and services it provides.^{1,22,241} It also includes funding support for the development of community-based initiatives like Men's Sheds (see Box 2) as well as research outputs including a longitudinal study of men's health.

While stakeholders have praised many of these policy design elements, some criticism has focused on its limited scope, poor governance and leadership, lack of delivery time frames and no independent evaluation process.²⁴¹

Box 3 Case study: Ireland's National Men's Health Policy (NMHP) 2008 – 2013

Ireland's NMHP had 10 strategic aims:²¹

1. Develop appropriate structures for men's health both nationally and locally to support policy implementation and to monitor and evaluate its implementation on an ongoing basis.
2. Promote an increased focus on men's health research in Ireland.
3. Develop health promotion initiatives that support men to adopt positive health behaviours and to increase control over their lives.
4. Develop health and social services with a clear focus on the delivery of services specifically designed to meet the needs and experiences of men.
5. Support the development of these health services, with a focus on preventative health.
6. Target specific men's health policy initiatives in the home that accommodate diversity within family structures and that reflect the multiple roles of men as husbands, partners, fathers and carers.
7. Develop a more holistic and gendered focus on health and personal development in schools, out-of-school settings and colleges within the context of the Health Promoting School and college models.

8. Target the workplace as a key setting in which to develop a range of men's health initiatives that are based on consultation and partnership-building with employers, unions, workers and other relevant statutory bodies.
9. Increase the availability of and access to facilities for sport and recreation for all men and safe social spaces for young people.
10. Build social capital within communities for men.

Stakeholders have concluded that while progress has been made across all NHMP's strategic aims, the degree to which things have improved varies significantly between them.²⁴² The least amount of progress has been made in developing workplace-based activities and the most progress has been made in developing men's health research (including outputs from the newly established National Centre for Men's Health).²⁴²

There has been a significant increase in community-based men's health activities including the large-scale national implementation of Men's Sheds (growing from 1 shed in 2009 to 450 in 2023) as well as local community sport-related projects.^{241,242} A men's health training package for front-line health workers called Engage was developed to improve skills in gender-sensitive service provision for men and has grown significantly since its introduction in 2012 through a 'Train the Trainers' model.^{241,242}

It is difficult to assess the impact the NMHP has had on broad men's health metrics like mortality. There was no implementation of a system for measuring changing health outcomes included in the policy framework.²⁴² It is also not possible to discern whether improvements are a result of the NMHP or from other public health policies introduced in Ireland during the same period.

However, at a community and individual level, stakeholders assert that men's health interventions have led to better health outcomes in the country.²⁴² In 2013 the NMHP completed its five-year course and a new national public health policy, 'Healthy Ireland' was published with a more overarching and broad scope and no significant discussions of gender differences in health outcomes.²⁴²

5.4

Stakeholder and expert perspectives on policy options

Creating a national men's health strategy is widely considered to be a key focal point for men's health policy. This detailed policy would draw on the general themes highlighted as most important in improving outcomes for men. This includes but is not limited to:

- A focus on priority conditions where disparities in outcomes are greatest for men. This would include cancers, CVD and suicide.^{1,19,239–241} An example of what policy approaches for specific conditions might look like is presented in a case study on cancer in Box 4, summarising key stakeholder suggestions
- Evaluation of the evidence on risk factors associated with these conditions and developing effective preventative approaches.^{1,19}
- Addressing health inequalities recorded between different groups of men^{7,14,15,125}
- Tackling suicide rates in men by addressing the underlying causes and using primary prevention measures. More focus is required on the male-specific drivers of suicide and on intervention methods which are effective for men²⁴³
- Reducing barriers preventing men from accessing health services and changing the provision of healthcare services to better meet men's needs^{1,15,60}
- Improving men's health literacy, particularly in the areas of cancer symptom recognition¹²
- Develop community-based and sporting interventions for men's health as a way of providing a gender-sensitive option for community healthcare. Experts note the importance of consultation with key stakeholders and that policies should be informed by the needs of partner organisations.^{214,217,227,244}

Several stakeholders and experts have called for a national men's health strategy in the UK. Stakeholders consulted in this area include men's health researchers, experts involved in other country's national men's health strategies, the Men's Health Forum and members of the APPG on Issues Affecting Men and Boys.^{1,19,240–242} Some of the key priority inclusions highlighted are as follows:

- Commission a new state of men's health in the UK/England report.
- Develop a national centre for men's health to increase research activity and be a focal point for men's health.
- Install a position of accountability in the Government to lead on men's health issues, such as creating a Minister for Men's Health or to give a minister specific responsibility for men's health.
- Develop men's health training programmes for health professionals.

Box 4 Policy approaches for specific conditions in men's health: cancer case study

The following policy suggestions relate specifically to potential actions that could improve cancer outcomes for men. Several of these approaches crossover and would improve outcomes for men in both prostate cancer and other cancers. These themes relate to work carried out by a range of stakeholders and academics with relevant expertise in cancer research.

- **Cancers**

- Policy interventions aimed at reducing some of the main preventable causes of cancer: smoking, excess bodyweight and alcohol consumption
- Health awareness campaigns for cancers, targeted at groups of men with higher risk. Promotion of symptom recognition and awareness of screening
- More research into the cancers that disproportionately effect men such as head and neck cancer. Raising awareness of the link between HPV and head and neck cancer for men is seen as important to make it clear that this virus is not solely related to cervical cancer

- **Prostate Cancer**

- Carry out and act on the findings of the recently announced TRANSFORM national prostate cancer screening trial using MRI screening methods

Alternative routes and pathways to testing need to be established which facilitate better access for underserved communities, and address the early diagnosis targets set out within the NHS Core20PLUS5 policy.* ²⁴⁵ Invest in the diagnostic pathway (including workforce, MRI, and where appropriate, AI technologies) so that patients receive a diagnosis or ruling out of prostate cancer within the Government's 28-day target, wherever they live. Focus on risk awareness messaging rather than symptom awareness (prostate cancer is largely asymptomatic). Campaigns should target at risk groups, particularly those who are higher-than-average-risk such as those in Black communities and those with family and/or genetic risk factors.

* Core20PLUS5 is a national NHS England policy approach to address healthcare inequalities at a national and system level. The approach targets the most deprived 20% of England's population with focus areas in maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and heart and circulatory management.

References

1. White, A. *et al.* (2022). [The need for a strategy on men's health](#). *Trends Urol. Mens Health*, Vol 13, 2–8.
2. Vos, T. *et al.* (2020). [Global burden of 369 diseases and injuries in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019](#). *The Lancet*, Vol 396, 1204–1222.
3. (2021). [Coronavirus \(COVID-19\) and the different effects on men and women in the UK, March 2020 to February 2021](#) - Office for National Statistics. Office for National Statistics.
4. (2023). [Sexually transmitted infections and screening for chlamydia in England: 2022 report](#). UK Health Security Agency.
5. Nasir, R. *et al.* (2022). [Suicides in England and Wales](#) - Office for National Statistics. Office for National Statistics.
6. Buxton, J. (2021). [National life tables – life expectancy in the UK](#) - Office for National Statistics. Office for National Statistics.
7. Rashid, T. *et al.* (2021). [Life expectancy and risk of death in 6791 communities in England from 2002 to 2019: high-resolution spatiotemporal analysis of civil registration data](#). *Lancet Public Health*, Vol 6, e805–e816. Elsevier.
8. Rea, M. *et al.* (2022). [Health state life expectancies by national deprivation deciles, England](#). Office for National Statistics.
9. (2014). [Key data: understanding of health and access to services](#). Men's Health Forum.
10. von Wagner, C. *et al.* (2007). [Functional health literacy and health-promoting behaviour in a national sample of British adults](#). *J. Epidemiol. Community Health*, Vol 61, 1086–1090.
11. Cook, E. J. *et al.* (2016). [Who uses NHS health checks? Investigating the impact of ethnicity and gender and method of invitation on uptake of NHS health checks](#). *Int. J. Equity Health*, Vol 15, 13.
12. Rowlands, G. *et al.* (2015). [A mismatch between population health literacy and the complexity of health information: an observational study](#). *Br. J. Gen. Pract. J. R. Coll. Gen. Pract.*, Vol 65, e379-386.
13. Griffith, D. M. (2012). [An intersectional approach to Men's Health](#). *J. Mens Health*, Vol 9, 106–112.
14. McCartney, G. *et al.* (2022). [Resetting the course of population health](#). Glasgow Centre for Population Health/University of Glasgow.
15. Shelswell, R. *et al.* (2023). [Investigating inequalities in men's health: a literature review](#). *Nurs. Stand. R. Coll. Nurs. G. B.* 1987,
16. White, A. *et al.* (2018). [Social determinants of male health: a case study of Leeds, UK](#). *BMC Public Health*, Vol 18, 160.
17. Buck, D. *et al.* (2012). [Clustering of unhealthy behaviours over time: implications for policy and practice](#). The King's Fund.
18. (2022). [Women's Health Strategy for England](#). Department of Health and Social Care.
19. Fletcher, N. (2022). *The Case for a Men's Health Strategy*.

20. (2023). [MPs to examine men's mental and physical health in new inquiry - Committees - UK Parliament.](#) *UK Parliament*.
21. (2008). *National Men's Health Policy 2008 - 2013*. Ireland, Department of Health and Children.
22. (2019). *National Men's Health Strategy 2020-2030*. Australian Government Department of Health.
23. (2023). [Understanding the drivers of healthy life expectancy: report.](#) Office for Health Improvement & Disparities.
24. (2023). [Non communicable diseases.](#) World Health Organization.
25. (2023). [British Heart Foundation - UK Factsheet.](#) British Heart Foundation.
26. Pinho-Gomes, A. C. *et al.* (2021). [Sex differences in prevalence, treatment and control of cardiovascular risk factors in England.](#) *Heart*, Vol 107, 462–467.
27. Pana, T. *et al.* (2023). [Sex-specific Lifetime Risk of Cardiovascular Events. The EPIC-Norfolk Prospective Population Cohort Study.](#) *Eur. J. Prev. Cardiol.*, SAGE Publications Ltd.
28. (2022). [Levelling up men's health: The case for a men's health strategy.](#) Men's Health Forum.
29. Rushton, R. (2021). [Ischaemic heart diseases deaths including comorbidities, England and Wales - Office for National Statistics.](#) Office for National Statistics.
30. (2023). [Obesity Profile - OHID.](#) Office for Health Improvement and Disparities.
31. (2017). [One In Ten: The Male Diabetes Crisis.](#) *Men's Health Forum*.
32. (2016). [Diabetes Prevalence Model.](#) Public Health England.
33. Raleigh, V. (2023). [The health of people from ethnic minority groups in England.](#) The King's Fund.
34. (2021). [Community based approaches to addressing high blood pressure with black African and Caribbean men.](#) National Institute for Health and Care Excellence.
35. (2017). [Black, Asian and other minority ethnic groups: promoting health and preventing premature mortality.](#) National Institute for Health and Care Excellence.
36. Caul, S. *et al.* (2019). [Cancer registration statistics, England Statistical bulletins - Office for National Statistics.](#) Office for National Statistics.
37. (2023). [Prostate cancer statistics.](#) Cancer Research UK.
38. Vickers, A. *et al.* (2023). [Current policies on early detection of prostate cancer create overdiagnosis and inequity with minimal benefit.](#) *BMJ*, Vol 381, e071082. British Medical Journal Publishing Group.
39. (2023). [Prostate cancer mortality statistics.](#) Cancer Research UK.
40. (2022). [Prostate-Specific Antigen \(PSA\) Test.](#) National Cancer Institute.
41. (2018). [Prostate cancer - Should I have a PSA test?](#) NHS.
42. (2023). [Transforming prostate cancer diagnosis.](#) Prostate Cancer UK.
43. Singh, S. *et al.* (2022). [Avoiding Unnecessary Biopsy after Multiparametric Prostate MRI with VERDICT Analysis: The INNOVATE Study.](#) *Radiology*, Vol 305, 623–630. Radiological Society of North America.
44. Leung, D. K.-W. *et al.* (2021). [Role of pre-biopsy multiparametric MRI in prostate cancer diagnosis: Evidence from the literature.](#) *Turk. J. Urol.*, Vol 47, S65–S70.

45. Ahmed, H. U. *et al.* (2017). Diagnostic accuracy of multi-parametric MRI and TRUS biopsy in prostate cancer (PROMIS): a paired validating confirmatory study. *The Lancet*, Vol 389, 815–822. Elsevier.
46. (2023). Biggest prostate cancer screening trial in decades to start in UK. Department of Health and Social Care.
47. Delon, C. *et al.* (2022). Differences in cancer incidence by broad ethnic group in England, 2013–2017. *Br. J. Cancer*, Vol 126, 1765–1773. Nature Publishing Group.
48. Lloyd, T. *et al.* (2015). Lifetime risk of being diagnosed with, or dying from, prostate cancer by major ethnic group in England 2008-2010. *BMC Med.*, Vol 13, 171.
49. Heath, L. *et al.* (2023). POSTbrief 53: Factors shaping gender incongruence and gender dysphoria, and impact on health services. Parliamentary Office of Science and Technology, UK Parliament.
50. (2020). Can trans women get prostate cancer? Prostate Cancer UK.
51. Deebel, N. A. *et al.* (2017). Prostate Cancer in Transgender Women: Incidence, Etiopathogenesis, and Management Challenges. *Urology*, Vol 110, 166–171.
52. (2023). Testicular cancer statistics. Cancer Research UK.
53. (2023). Penile cancer statistics. Cancer Research UK.
54. White, A. *et al.* (2009). The excess burden of cancer in men in the UK. National Cancer Intelligence Network; Cancer Research UK.
55. (2022). Cancer incidence for common cancers. Cancer Research UK.
56. (2022). Cancer mortality for common cancers. Cancer Research UK.
57. (2022). Lung cancer statistics. Cancer Research UK.
58. UK, C. R. (2021). Men's skin cancer rates increase by 50% over decade. *Cancer Research UK - Cancer News.*
59. Revie, L. *et al.* (2022). Adult smoking habits in the UK. Office for National Statistics.
60. Fish, J. A. *et al.* (2019). Understanding variation in men's help-seeking for cancer symptoms: A semistructured interview study. *Psychol. Men Masculinities*, Vol 20, 61–70. Educational Publishing Foundation.
61. Fish, J. A. *et al.* (2015). Psychosocial factors that influence men's help-seeking for cancer symptoms: a systematic synthesis of mixed methods research. *Psychooncology.*, Vol 24, 1222–1232.
62. MacLean, A. *et al.* (2017). Does gender matter? An analysis of men's and women's accounts of responding to symptoms of lung cancer. *Soc. Sci. Med.* 1982, Vol 191, 134–142.
63. Keeble, S. *et al.* (2014). Variation in promptness of presentation among 10,297 patients subsequently diagnosed with one of 18 cancers: Evidence from a National Audit of Cancer Diagnosis in Primary Care. *Int. J. Cancer*, Vol 135, 1220–1228.
64. Forbes, L. J. L. *et al.* (2014). Risk factors for delay in symptomatic presentation: a survey of cancer patients. *Br. J. Cancer*, Vol 111, 581–588. Nature Publishing Group.
65. (2017). Head and neck cancers statistics. Cancer Research UK.
66. (2017). Head and neck cancers risk. Cancer Research UK.
67. Mehanna, H. *et al.* (2013). Prevalence of human papillomavirus in oropharyngeal and nonoropharyngeal head and neck cancer--systematic review and meta-analysis of trends by time and region. *Head Neck*, Vol 35, 747–755.

68. Gormley, M. *et al.* (2022). [Reviewing the epidemiology of head and neck cancer: definitions, trends and risk factors.](#) *Br. Dent. J.*, Vol 233, 780–786. Nature Publishing Group.
69. Schache, A. G. *et al.* (2016). HPV-Related Oropharynx Cancer in the United Kingdom: An Evolution in the Understanding of Disease Etiology. *Cancer Res.*, Vol 76, 6598–6606.
70. (2015). [Cervical cancer statistics.](#) Cancer Research UK.
71. Falcaro, M. *et al.* (2021). [The effects of the national HPV vaccination programme in England, UK, on cervical cancer and grade 3 cervical intraepithelial neoplasia incidence: a register-based observational study.](#) *The Lancet*, Vol 398, 2084–2092.
72. Earnshaw, A. (2018). Statement on HPV vaccination. *Jt. Comm. Vaccin. Immun.*,
73. (2023). [WHO EMRO | Infectious diseases | Health topics.](#) World Health Organization (WHO).
74. Bunn, S. (2017). [POSTnote 545. UK Trends in Infectious Disease.](#) POST.
75. (2023). [Chronic respiratory diseases.](#) World Health Organization (WHO).
76. Bostock, B. (2021). [Gender and respiratory conditions: are men at increased risk?](#) *Trends Urol. Mens Health*, Vol 12, 12–15.
77. Fuseini, H. *et al.* (2017). [Mechanisms Driving Gender Differences in Asthma.](#) *Curr. Allergy Asthma Rep.*, Vol 17, 19.
78. Gut-Gobert, C. *et al.* (2019). [Women and COPD: do we need more evidence?](#) *Eur. Respir. Rev.*, Vol 28, European Respiratory Society.
79. Raulf, M. *et al.* (2017). [Gender-related aspects in occupational allergies – Secondary publication and update.](#) *World Allergy Organ. J.*, Vol 10, 44.
80. Neyrolles, O. *et al.* (2009). [Sexual Inequality in Tuberculosis.](#) *PLoS Med.*, Vol 6, e1000199.
81. (2023). [TB incidence and epidemiology in England, 2021.](#) UK Health Security Agency.
82. (2022). [The COVID-19 Sex-Disaggregated Data Tracker | Global Health 50/50.](#)
83. (2021). [The COVID-19 sex-disaggregated Data tracker.](#) European Region Data Update. Global Health 5050.
84. White, A. *et al.* (2020). [COVID -19: biological factors in men's vulnerability.](#) *Trends Urol. Mens Health*, Vol 11, 7.
85. Verdecchia, P. *et al.* (2020). [The pivotal link between ACE2 deficiency and SARS-CoV-2 infection.](#) *Eur. J. Intern. Med.*, Vol 76, 14–20.
86. (2023). [Excess mortality in England and English regions.](#) Office for Health Improvement & Disparities.
87. White, A. (2020). [Men and COVID-19: the aftermath.](#) *Postgrad. Med.*, Vol 132, 18–27.
88. (2020). [Trends in HIV testing, new diagnoses and people receiving HIV-related care in the United Kingdom: data to the end of December 2019.](#) Public Health England.
89. (2023). [Record HIV testing among gay and bisexual men.](#) *GOV.UK.*
90. (2022). [Reducing sexually transmitted infections \(STIs\).](#) NICE.
91. (2023). [Hepatitis B in England – 2023 report.](#) UK Health Security Agency.
92. (2022). [Hepatitis C in England 2022.](#) UK Health Security Agency.
93. Bardsley, M. *et al.* (2022). [Improving our understanding of the disproportionate incidence of STIs in heterosexual-identifying people of](#)

- [black Caribbean heritage: findings from a longitudinal study of sexual health clinic attendees in England](#). *Sex. Transm. Infect.*, Vol 98, 23–31. BMJ Publishing Group Ltd.
94. Baker, C. *et al.* (2023). [Mental health statistics: prevalence, services and funding in England](#).
 95. (2020). [Get it off your chest - Men's mental health 10 years on](#). MIND.
 96. (2023). [NHS Digital](#). NHS.
 97. (2023). [Health and social care - Office for National Statistics](#). Office for National Statistics.
 98. (2021). [Men and mental health](#). Mental Health Foundation.
 99. (2023). [National system launched to rapidly identify trends in suicides](#). Department of Health and Social Care.
 100. White, A. (2023). [Populations at special health risk: Men](#). in *Reference Module in Biomedical Sciences*. B9780323999670000193. Elsevier.
 101. Breen, P. *et al.* (2022). [Deaths related to drug poisoning in England and Wales](#). Office for National Statistics.
 102. Stein, C. (2018). [Mind-your-language-how-men-talk-about-mental-health-18.pdf](#). Men's Health Forum.
 103. (2022). [Psychological Therapies, Annual report on the use of IAPT services, 2021-22](#). NHS Digital.
 104. (2021). [Men are much more likely than women to have misconceptions about mental health | YouGov](#). YouGov.
 105. (2021). [Suicide by middle-aged men](#). National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH).
 106. Baker, C. (2022). [Suicide statistics](#). House of Commons Library.
 107. (2016). [Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014](#). NHS Digital.
 108. Attwell, C. *et al.* (2022). [Cost of living and depression in adults, Great Britain - Office for National Statistics](#). Office for National Statistics.
 109. (2022). [The impact of body image on mental and physical health](#). House of Commons Health and Social Care Committee.
 110. Crofts, S. *et al.* (2020). [Our population – Where are we? How did we get here? Where are we going?](#) Office for National Statistics.
 111. Raleigh, V. (2022). [What is happening to life expectancy in England?](#) The King's Fund.
 112. Buxton, J. (2021). [Single-year life tables, UK: 1980 to 2020](#). Office for National Statistics.
 113. Raleigh, V. (2018). [Stalling life expectancy in the UK](#). The King's Fund.
 114. [expert reaction to paper on health and social care spending and excess deaths in England | Science Media Centre](#).
 115. Hiam, L. *et al.* (2017). [Why has mortality in England and Wales been increasing? An iterative demographic analysis](#). *J. R. Soc. Med.*, Vol 110, 153–162. SAGE Publications.
 116. Loopstra, R. *et al.* (2016). [Austerity and old-age mortality in England: a longitudinal cross-local area analysis, 2007–2013](#). *J. R. Soc. Med.*, Vol 109, 109–116. SAGE Publications.
 117. Walsh, D. *et al.* (2022). [Bearing the burden of austerity: how do changing mortality rates in the UK compare between men and women?](#) *J Epidemiol Community Health*, Vol 76, 1027–1033. BMJ Publishing Group Ltd.
 118. (2015). [English indices of deprivation 2015](#). Ministry of Housing, Communities & Local Government.

119. Raleigh, V. (2021). [How much longer and further are health inequalities set to rise?](#) The King's Fund.
120. (2021). [Life expectancy declining in many English communities even before pandemic | Imperial News | Imperial College London.](#) *Imperial News*.
121. White, C. (2022). [Health state life expectancies, UK - Office for National Statistics.](#) Office for National Statistics.
122. Eikemo, T. A. *et al.* (2017). [The First Pan-European Sociological Health Inequalities Survey of the General Population: The European Social Survey Rotating Module on the Social Determinants of Health.](#) *Eur. Sociol. Rev.*, Vol 33, 137–153.
123. Dahlgren, G. *et al.* (1991). Policies and strategies to promote social equity in health. Background document to WHO - Strategy paper for Europe. *Inst. Futur. Stud. Arbetsrapport*, Vol 14,
124. (2017). [Chapter 6: social determinants of health.](#) Public Health England.
125. Williams, E. *et al.* (2022). [What are health inequalities?](#) The King's Fund.
126. Benzeval, M. *et al.* (2014). [How does money influence health? | JRF.](#) Joseph Rowntree Foundation.
127. (2023). [Public Health Outcomes Framework - Data - OHID.](#) Office for Health Improvement & Disparities.
128. Viner, R. M. *et al.* (2012). Adolescence and the social determinants of health. *Lancet Lond. Engl.*, Vol 379, 1641–1652.
129. Ross, C. E. *et al.* (2012). Education and the gender gaps in health and mortality. *Demography*, Vol 49, 1157–1183.
130. Huisman, M. *et al.* (2005). Educational inequalities in cause-specific mortality in middle-aged and older men and women in eight western European populations. *Lancet Lond. Engl.*, Vol 365, 493–500.
131. OECD (2019). [Life expectancy by sex and education level.](#) OECD.
132. (2022). [Education and training statistics for the UK, Reporting year 2022.](#) Office for National Statistics.
133. Lewis, J. *et al.* (2023). [Equality of access and outcomes in higher education in England.](#)
134. Bird, W. (2021). Improving health in coastal communities. *BMJ*, Vol 374, n2214.
135. (2020). [Homes, health and COVID-19: How poor-quality homes have contributed to the pandemic.](#) Centre for Ageing Better.
136. Novoa, A. M. *et al.* (2015). [How substandard dwellings and housing affordability problems are associated with poor health in a vulnerable population during the economic recession of the late 2000s.](#) *Int. J. Equity Health*, Vol 14, 120.
137. Howells, T. *et al.* (2023). ['Hidden' homelessness in the UK: evidence review - Office for National Statistics.](#) Office for National Statistics.
138. Bradby, H. *et al.* (2015). [Public Health Aspects of Migrant Health: A Review of the Evidence on Health Status for Refugees and Asylum Seekers in the European Region.](#) WHO Regional Office for Europe.
139. Asif, Z. *et al.* (2022). [Structural barriers to refugee, asylum seeker and undocumented migrant healthcare access. Perceptions of Doctors of the World caseworkers in the UK.](#) *SSM - Ment. Health*, Vol 2, 100088.
140. (2023). [Asylum and resettlement datasets.](#) Home Office.
141. (2023). [Gender, safety and health - A guide for UNISON safety reps.](#) UNISON.

142. (2021). [WHO/ILO Joint Estimates of the Work-related Burden of Disease and Injury, 2000–2016](#). World Health Organization (WHO), International Labour Organization (ILO).
143. (2023). [Work-related fatal injuries in Great Britain](#). Health and Safety Executive.
144. (2010). [The burden of occupational cancer in Great Britain](#). Health and Safety Executive.
145. Robards, J. (2022). [National population projections - Office for National Statistics](#). Office for National Statistics.
146. Barton, F. *et al.* (2023). [Death registration summary statistics, England and Wales - Office for National Statistics](#). Office for National Statistics.
147. Pinna, F. *et al.* (2022). [Mental health in transgender individuals: a systematic review](#). *Int. Rev. Psychiatry*, Vol 34, 292–359. Taylor & Francis.
148. Erlangsen, A. *et al.* (2023). [Transgender Identity and Suicide Attempts and Mortality in Denmark](#). *JAMA*, Vol 329, 2145–2153.
149. (2022). [Smoking and tobacco: applying All Our Health](#). Office for Health Improvement & Disparities.
150. Archbold, M. *et al.* (2023). [Deprivation and the impact on smoking prevalence, England and Wales - Office for National Statistics](#). Office for National Statistics.
151. O'Connell, N. *et al.* (2022). [The effectiveness of smoking cessation interventions for socio-economically disadvantaged women: a systematic review and meta-analysis](#). *Syst. Rev.*, Vol 11, 111.
152. (2023). [Statistics on NHS Stop Smoking Services in England - April 2022 to September 2022](#). NHS Digital.
153. Kotz, D. *et al.* (2014). 'Real-world' effectiveness of smoking cessation treatments: a population study. *Addict. Abingdon Engl.*, Vol 109, 491–499.
154. Ho, F. K. *et al.* (2021). [Changes over 15 years in the contribution of adiposity and smoking to deaths in England and Scotland](#). *BMC Public Health*, Vol 21, 169.
155. (2022). [Decrease in obesity among primary-aged children in 2021/22, latest statistics show](#). NHS Digital.
156. (2021). [New era of public health to tackle inequalities and level up the UK](#). *Office for Health Improvement and Disparities*.
157. Northstone, K. *et al.* (2010). Dietary patterns of men in ALSPAC: associations with socio-demographic and lifestyle characteristics, nutrient intake and comparison with women's dietary patterns. *Eur. J. Clin. Nutr.*, Vol 64, 978–986.
158. (2022). [Health Surveys for England 2021. Part 3: Drinking alcohol](#). NHS Digital.
159. (2019). [Global health estimates: Leading causes of death](#). World Health Organization (WHO).
160. (2023). [Reported road casualties Great Britain, provisional results: 2022](#). Department of Transport.
161. (2018). [Reducing unintentional injuries on the roads among children and young people under 25 years](#). Public Health England.
162. Hadley, D. R. A. (2021). [How is a man supposed to be a man? Male childlessness a Life Course Disrupted](#). Berghahn Books.
163. Hadley, R. A. (2021). 'No longer invincible': the impact of involuntary childlessness on older men. *Phys. Ther. Rev.*, Vol 26, 328–343.

164. Levine, H. *et al.* (2023). [Temporal trends in sperm count: a systematic review and meta-regression analysis of samples collected globally in the 20th and 21st centuries](#). *Hum. Reprod. Update*, Vol 29, 157–176.
165. Lau Clayton, C. (2016). [The Lives of Young Fathers: A Review of Selected Evidence](#). *Soc. Policy Soc.*, Vol 15, 129–140.
166. Mann, U. *et al.* (2020). Reasons for worldwide decline in male fertility. *Curr. Opin. Urol.*, Vol 30, 296–301.
167. Oud, M. S. *et al.* (2022). [A de novo paradigm for male infertility](#). *Nat. Commun.*, Vol 13, 154. Nature Publishing Group.
168. Colvin, H. (2023). [General health by age, sex and deprivation, England and Wales - Office for National Statistics](#). Office for National Statistics.
169. Jose-Miller, A. B. *et al.* (2007). Infertility. *Am. Fam. Physician*, Vol 75, 849–856.
170. (2015). [Reducing social isolation across the lifecourse](#). Public Health England, UCL Institute of Health Equity.
171. White, A. *et al.* (2020). [Social isolation and loneliness: a hidden killer](#). *Trends Urol. Mens Health*, Vol 11, 31–35.
172. Holt-Lunstad, J. *et al.* (2015). Loneliness and social isolation as risk factors for mortality: a meta-analytic review. *Perspect. Psychol. Sci. J. Assoc. Psychol. Sci.*, Vol 10, 227–237.
173. Leigh-Hunt, N. *et al.* (2017). An overview of systematic reviews on the public health consequences of social isolation and loneliness. *Public Health*, Vol 152, 157–171.
174. Santini, Z. I. *et al.* (2016). Social relationships, loneliness, and mental health among older men and women in Ireland: A prospective community-based study. *J. Affect. Disord.*, Vol 204, 59–69.
175. Oliffe, J. L. *et al.* (2019). Unpacking Social Isolation in Men's Suicidality. *Qual. Health Res.*, Vol 29, 315–327.
176. Beach, B. *et al.* (2014). [Isolation: The emerging crisis for older men](#). Independent Age.
177. White, D. C., Alan (2016). *Promoting Men's Mental Health*. CRC Press.
178. Schwartz, E. *et al.* (2018). [Social network changes among older Europeans: the role of gender](#). *Eur. J. Ageing*, Vol 15, 359. Springer.
179. Wang, Y. *et al.* (2013). [Do men consult less than women? An analysis of routinely collected UK general practice data](#). *BMJ Open*, Vol 3, e003320. British Medical Journal Publishing Group.
180. (2020). [Summary Report - outpatient appointments by gender](#). NHS England.
181. (2022). [NHS Health Check Programme, Patients Recorded as Attending and Not Attending, 2012-13 to 2017-18](#). NHS Digital.
182. (2023). [NHS England: Screening and earlier diagnosis](#). NHS England.
183. (2023). [Bowel screening age lowered to 51 in Wales | News](#). Bowel Cancer UK.
184. von Wagner, C. *et al.* (2011). [Inequalities in participation in an organized national colorectal cancer screening programme: results from the first 2.6 million invitations in England](#). *Int. J. Epidemiol.*, Vol 40, 712–718.
185. Hirst, Y. *et al.* (2018). [Uptake of the English Bowel \(Colorectal\) Cancer Screening Programme: an update 5 years after the full roll-out](#). *Eur. J. Cancer*, Vol 103, 267–273.
186. Alexandrou, B. (2023). [Men's Health Report | Healthwatch Barnet](#). Healthwatch Barnet.

187. Macdonald, J. A. *et al.* (2022). Men's and boys' barriers to health system access: a literature review. *Aust. Gov. Dep. Health Aged Care*,
188. (2023). [Men's Health Week survey shows long waiting times and inconvenient opening hours main reasons men don't go to the GP | Men & Boys Coalition](#). Men and Boys Coalition.
189. Ragonese, C. *et al.* (2018). Masculine Norms and Men's Health: Making the Connections. *Wash. DC Promundo-US*,
190. Rowlands, G. P. *et al.* (2013). [Characteristics of people with low health literacy on coronary heart disease GP registers in South London: a cross-sectional study](#). *BMJ Open*, Vol 3, e001503.
191. Simpson, R. M. *et al.* (2020). [Health literacy levels of British adults: a cross-sectional survey using two domains of the Health Literacy Questionnaire \(HLQ\)](#). *BMC Public Health*, Vol 20, 1819.
192. Robb, K. *et al.* (2009). [Public awareness of cancer in Britain: a population-based survey of adults](#). *Br. J. Cancer*, Vol 101, S18–S23.
193. Rennie, D. (2023). [The Cancer Awareness Measures \(CAM\)](#). Cancer Research UK.
194. Patnick, J. (2014). [Why do we see gender differences in bowel cancer screening? - UK Health Security Agency](#). UK Health Security Agency.
195. White, A. *et al.* (2018). A review of sex-related differences in colorectal cancer incidence, screening uptake, routes to diagnosis, cancer stage and survival in the UK. *BMC Cancer*, Vol 18, 906.
196. Roy, R. K. *et al.* (2017). [Attitudes Toward Testicular Cancer and Self-Examination Among Northern Irish Males](#). *Am. J. Mens Health*, Vol 11, 253–261.
197. Peltzer, K. *et al.* (2015). Knowledge, Attitudes and Practice of Testicular Self-examination among Male University Students from Bangladesh, Madagascar, Singapore, South Africa and Turkey. *Asian Pac. J. Cancer Prev. APJCP*, Vol 16, 4741–4743.
198. Gibney, S. *et al.* (2020). Increasing Health Literacy May Reduce Health Inequalities: Evidence from a National Population Survey in Ireland. *Int. J. Environ. Res. Public Health*, Vol 17, 5891.
199. Etienne (2018). [Addressing masculinity and men's health to advance universal health and gender equality](#). *Rev. Panam. Salud Pública*, Vol 42, 196.
200. Gough, B. *et al.* (2021). [Young masculinities across five European countries: performing under pressure](#). *J. Youth Stud.*, Vol 24, 77–90. Routledge.
201. Gough, B. *et al.* (2020). *Mental health, men and culture: how do sociocultural constructions of masculinities relate to men's mental health help-seeking behaviour in the WHO European region?* WHO Regional Office for Europe.
202. Mahalik, J. R. *et al.* (2007). Masculinity and perceived normative health behaviors as predictors of men's health behaviors. *Soc. Sci. Med.* 1982, Vol 64, 2201–2209.
203. (2017). [Time for Action: State of the world's fathers 2017](#). MenCare.
204. (2023). [Major conditions strategy: case for change and our strategic framework](#). Department of Health & Social Care.
205. Robertson, S. *et al.* (2017). [Men and health promotion in the United Kingdom: 20 years further forward?](#) *Health Educ. J.*, Vol 76, 102–113.
206. (2023). [Suicide prevention in England: 5-year cross-sector strategy](#). Department of Health & Social Care.

207. (2023). [Prime Minister to create 'smokefree generation' by ending cigarette sales to those born on or after 1 January 2009](#). Department of Health & Social Care.
208. (2021). [40 community diagnostic centres launching across England](#). Department of Health and Social Care.
209. Wickens, C. *et al.* (2022). [Are community diagnostic centres really moving care closer to home?](#) The King's Fund.
210. (2018). [Minimum unit pricing](#). Scottish Government.
211. Wyper, G. M. A. *et al.* (2023). [Evaluating the impact of alcohol minimum unit pricing on deaths and hospitalisations in Scotland: a controlled interrupted time series study](#). *The Lancet*, Vol 401, 1361–1370. Elsevier.
212. RSPH (2021). [Blog: Levelling up men's health: it's time for a strategy](#). *Royal Society for Public Health*.
213. Hanlon, C. A. *et al.* (2022). [Evaluating the role and effectiveness of co-produced community-based mental health interventions that aim to reduce suicide among adults: A systematic review](#). *Health Expect. Int. J. Public Particip. Health Care Health Policy*, Vol 26, 64–86.
214. (2016). [Recommendations | Community engagement: improving health and wellbeing and reducing health inequalities | Guidance | NICE](#). National Institute for Health and Care Excellence.
215. (2023). [UK Men's Sheds](#). *UKMSA Men's Sheds Association*.
216. Kelly, D. *et al.* (2021). [The impact of community Men's Sheds on the physical health of their users](#). *Health Place*, Vol 71, 102649.
217. Lowry, R. *et al.* (2022). [Step By Step Project Evaluation Report](#). University of Chichester.
218. Culph, J. S. *et al.* (2015). [Men's Sheds and the experience of depression in older Australian men](#). *Aust. Occup. Ther. J.*, Vol 62, 306–315.
219. Kelly, D. *et al.* (2019). [Men's Sheds: A conceptual exploration of the causal pathways for health and well-being](#). *Health Soc. Care Community*, Vol 27, 1147–1157.
220. Ballinger, M. L. *et al.* (2009). [More than a place to do woodwork: a case study of a community-based Men's Shed](#). *J. Mens Health*, Vol 6, 20–27.
221. Lefkowich, M. *et al.* (2018). [Men's health in alternative spaces: exploring men's sheds in Ireland](#). *Health Promot. Int.*, Vol 33, 525–535.
222. Crabtree, L. *et al.* (2017). [Men's sheds: the perceived health and wellbeing benefits](#). *Work. Older People*, Vol 22, 101–110. Emerald Publishing Limited.
223. (2023). [Who We Are | Andy's Man Club](#). *Andy's Man Club*.
224. Wilcock, R. *et al.* (2021). [Designing community sports-based programmes for men with mental illness: A qualitative study of the Offload rugby league programme](#). *Ment. Health Phys. Act.*, Vol 20, 100386.
225. Oliffe, J. L. *et al.* (2020). [Community-based men's health promotion programs: eight lessons learnt and their caveats](#). *Health Promot. Int.*, Vol 35, 1230–1240.
226. Pringle, A. *et al.* (2013). [Delivering men's health interventions in English Premier League football clubs: key design characteristics](#). *Public Health*, Vol 127, 716–726.
227. Day, J. *et al.* (2021). [Living with Obesity: Men's experiences of losing and gaining weight and the implications for policy and services](#). Healthwatch Essex.

228. Bottorff, J. L. *et al.* (2021). Scaling up a community-led health promotion initiative: Lessons learned and promising practices from the Healthy Weights for Children Project. *Eval. Program Plann.*, Vol 87, 101943.
229. Weber, P. *et al.* (2022). Development of a Framework for Scaling Up Community-Based Health Promotion: A Best Fit Framework Synthesis. *Int. J. Environ. Res. Public Health*, Vol 19, 4773.
230. Koorts, H. *et al.* (2022). Tensions and Paradoxes of Scaling Up: A Critical Reflection on Physical Activity Promotion. *Int. J. Environ. Res. Public Health*, Vol 19, 14284.
231. McGrath, A. *et al.* (2022). Sheds for life: health and wellbeing outcomes of a tailored community-based health promotion initiative for men's sheds in Ireland. *BMC Public Health*, Vol 22, 1590.
232. McGrath, A. *et al.* (2022). An Economic Evaluation of 'Sheds for Life': A Community-Based Men's Health Initiative for Men's Sheds in Ireland. *Int. J. Environ. Res. Public Health*, Vol 19, 2204.
233. Ormsby, J. *et al.* (2010). Older men's participation in community-based men's sheds programmes. *Health Soc. Care Community*, Vol 18, 607–613.
234. Ayres, L. *et al.* (2018). Health and environmental impacts of a regional Australian Men's Shed program. *Aust. J. Rural Health*, Vol 26, 65–67.
235. Henwood, M. *et al.* (2017). Men's health and communities of practice in Australia. *J. Health Organ. Manag.*, Vol 31, 207–222. Emerald Publishing Limited.
236. Anstiss, D. *et al.* (2018). Men's re-placement: Social practices in a Men's Shed. *Health Place*, Vol 51, 217–223.
237. Wilson, N. J. *et al.* (2013). A narrative review of Men's Sheds literature: reducing social isolation and promoting men's health and well-being. *Health Soc. Care Community*, Vol 21, 451–463.
238. McGrath, A. *et al.* (2021). Study protocol: evaluation of sheds for life (SFL): a community-based men's health initiative designed "for shedders by shedders" in Irish Men's sheds using a hybrid effectiveness-implementation design. *BMC Public Health*, Vol 21, 801.
239. (2018). Strategy on the health and well-being of men in the WHO European Region. World Health Organization (WHO).
240. (2018). The health and well-being of men in the WHO European Region: better health through a gender approach. World Health Organization (WHO).
241. Baker, P. (2015). National men's health policies: can they help? *Trends Urol. Mens Health*, Vol 6, 24–26.
242. Baker, P. (2015). *Review of the national men's health policy action plan 2008-2013.*
243. (2022). APPG on Issues Affecting Men and Boys: Tackling Male Suicide - A New 'Whole System' Approach. All-Party Parliamentary Group on Issues Affecting Men and Boys.
244. (2018). Health matters: community-centred approaches for health and wellbeing. Public Health England.
245. (2023). NHS England Core20PLUS5 (adults) – an approach to reducing healthcare inequalities. NHS England.

Contributors

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- Members of the POST Board*
- Professor Louis Appleby, University of Manchester
- Peter Baker, Global Action on Men's Health*
- Mark Brooks, Men and Boys' Health, Inclusion and Domestic Abuse, The ManKind Initiative*
- Cancer Research UK*
- Dr Charlotte Campbell, CLOSER
- Professor Carmen Clayton, Leeds Trinity University
- Dr John Day, University of Essex*
- Department of Health and Social Care / Office for Health Improvement and Disparities*
- Professor Peter Goldblatt, UCL
- Emma Goldsmith, Rugby League Cares*
- Professor Brendan Gough, Leeds Beckett University
- Dr Robin Hadley, Manchester Metropolitan University
- Professor Jamie Hartmann-Boyce, University of Massachusetts, Amherst
- Dr Ruth Lowry, University of Essex*
- Professor Elizabeth Marsh, University of Derby*
- Glen Poole, Australia Men's Health Forum*
- Prostate Cancer UK*
- Dr Noel Richardson, Institute of Technology Carlow Ireland
- Professor Gillian P Rowlands, Newcastle University*

- Robert Shelswell, University of Plymouth*
- Martin Tod, The Men's Health Forum
- Oliver Vikse, Andy's Man Club
- Dr David Walsh, Glasgow Centre for Population Health, University of Glasgow*
- Professor Alan White, Leeds Beckett University*

*Denotes people and organisations who acted as external reviewers of the briefing.

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